West Virginia Electronic Health Records (EHR)
Provider Incentive Program (PIP)
For Eligible Providers
Meaningful Use Attestation Guide

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Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Molina Healthcare. It is healthcare data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of healthcare to an individual; or the past, present, or future payment for the provision of healthcare to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Version	Date	Author	Action/Summary of Changes	Status
1.0	03/2012	Karla Battle	First Draft	Active
	01/29/2014	Joseph White	Final QA	Submission

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1. Introduction

Starting in 2014, providers participating in the EHR Incentive Program who have met Stage 1 Meaningful Use requirements for two years will need to meet Stage 2 Meaningful Use requirements. This manual will assist you with your Stage 2 attestation.

CMS has defined Meaningful Use in the following three stages:

- Stage 1 sets the baseline for electronic data capture and information sharing. Provider must receive two EHR Incentive Program payments for meeting these requirements before moving on to Stage 2.
- Stage 2, which is being implemented in 2014
- Stage 3, which is expected to be implemented sometime in the future. CMS will continue to expand on the current baseline and continue to develop through future rule making.

The Stage 2 requirements **ONLY** are addressed in this manual and summarized below.

According to the guidelines for the EHR Incentive Program, for 2014 all Meaningful Use reporting periods are 90 days, regardless of the reporting period used in prior years. After 2014, all Meaningful Use providers will need to meet the standards for their particular payment year.

- EHRs must meet the new 2014 standards and certification criteria. If additional information is needed, please visit ONC's new 2014 Certification Programs and Policy page: http://www.healthit.gov/policy-researchers-implementers/certification-and-ehr-incentives

Along with meeting the 2014 EHR criteria, the Stage 2 Meaningful Use requirements are summarized as follows:

- There are a total of 23 Meaningful Use objectives. To qualify for an incentive payment, 20 of these 23 objectives must be met. In addition, responses to Clinical Quality Measures (CQM) questions are required.
  - There are 17 required core objectives.
  - There are six menu measure objectives and three menu measures must be selected.

- Eligible Providers must also report on nine of the 64 total clinical quality measures by submitting the CQM data to the NJ state agency. CMS provided the following guidance for the CQMs.

  "CMS has also published a recommended core set of CQMs for eligible professionals that focus on high-priority health conditions and best-practices for care delivery.

  *9 CQMs for **adult populations** that meet all of the program requirements*

  *9 CQMs for **pediatric populations** that meet all of the program requirements*

  These recommended core sets focus on conditions that contribute to the morbidity and mortality of most Medicare and Medicaid beneficiaries and also focus on areas that represent national public health priorities or disproportionately drive health care costs. If one of these sets is applicable to your patient population, CMS recommends choosing these 9 CQMs."

  http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/Stage2_Guide_Eps_9_23_13.pdf

1.1 Eligible Professionals (EP)

Attestation for Year 2 and beyond is not solely concentrated on meeting Meaningful Use and reporting on CQMs. You are still required to be eligible for the incentive program for WV Medicaid. The Center for Medicare & Medicaid Services (CMS) has defined eligible professionals for the Electronic Health Record Incentive program for Medicaid as follows:

- **An actively enrolled Medicaid Provider with the State Medicaid program with one of the below provider types:**

  - ❑ Physician (primarily doctors of medicine and doctors of osteopathy)
  - ❑ Nurse practitioners
  - ❑ Certified nurse-midwife
  - ❑ Dentist
  - ❑ A Physician Assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant where:
    1. PA is the primary provider in a clinic
    2. PA is a clinical or medical director at a clinical site of practice; or
    3. PA is an owner of an RHC

- **To be eligible for the incentive payment, professional providers meeting the provider type requirement above must also meet one of the following Medicaid patient volume criteria:**

  - ❑ Have a minimum 30% Medicaid patient volume
  - ❑ Have a minimum 20% Medicaid patient volume, and also be enrolled as a practicing physician with a specialty of pediatrician with WV Medicaid
  - ❑ Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

- **The provider must also not practice predominately in a hospital setting. Providers who see more than 90% of their Medicaid patients in a hospital inpatient or emergency room setting are considered to be practicing predominately in a hospital setting.**
- **Providers must indicate if they are adopting, upgrading, or implementing a certified EHR solution during their attestation process to proceed with submission. For Year 1, providers do not have to demonstrate Meaningful Use. Meaningful Use question responses will be recorded if completed, but not scored for Year 1.**

The WV EHR Incentive Payment Solution will verify providers meet the above requirements by validating the provider's claims-based data within the MMIS upon incentive payment registration and attestation. In addition to validating the above criteria electronically, the system will perform the following validations:

- ❑ Providers must pass a systematic check of claims volume and place of service relative to the amount of Medicaid patient volume they claim to have seen during the attestation process they complete online. ***Claims for providers for patients within a hospital setting will not be considered for their Medicaid patient volume since providers are supposed to by predominately office based.***
- ❑ Providers will not be paid if currently under review with the State of West Virginia or not actively enrolled with Medicaid.
- ❑ The provider's Pay-To providers indicated within the NLR registration must also be an active Medicaid provider to receive payment on behalf of the attesting provider.

1.2 Registering with CMS

The provider does not need to register with CMS from Year 2 and beyond. However, if the information reported to CMS needs to be updated, the provider may log into the CMS registration website to do so.

If you review your CMS registration and no changes are made, you will still need to submit the registration. If you do not, this will stop the processing of your attestation.

2. Information Needed

Before a provider can begin to complete the EHR Incentive Program attestation process, the provider or clinic/practice will need to gather all of the information necessary to complete the attestation correctly. The West Virginia EHR Incentive program has created a workbook to guide the provider or representative user through obtaining the appropriate data needed to complete an attestation successfully. The workbook is available in PDF format. This workbook is embedded within this User Manual in the immediate pages below, as well as available on the www.wvmmis.com web portal. The Provider Workbook provides the questions CMS requires and can be used to gather answers before logging into the WV EHR Incentive Payment online application. The items below provide the minimum that is needed in order to use the Provider Incentive Program application in addition to the workbook.

2.1 Eligible Provider Attestation Workbook - Overview

The workbook describes the eligibility requirements, the Meaningful Use Core and Menu Measures, and the Clinical Quality Measures for the professional provider and web requirements for utilizing the WV EHR Incentive payment attestation solution. It can also hold your responses before accessing the application. A sample page from the workbook is shown below.

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

WV Electronic Health Record Provider Incentive Program

Hospital Attestation Provider Worksheet

Meaningful Use Core Measures

#	Question	Response				
Meaningful Use Core Measures Responses to all questions are required.						
1	**CPOE for Medications Orders** **Objective:** Use computerized provider order entry (CPOE) for medication orders directly entered by a licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines **Measure:** More than 30 percent of all unique patients with at least one medication in their medication list seen by the EP have at least one medication order entered using CPOE **Numerator:** The number of patients in the denominator that have at least one medication order entered using CPOE **Denominator:** Number of unique patients with at least one medication in their medication list seen by the eligible hospital or CAH during the EHR period. **Exclusion:** Any EP who writes fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement **Does this exclusion apply to you?** **Numerator:** The number of patients in the denominator that have at least one medication order entered using CPOE **NOTE: Answer is required if Exclusion does not apply to you.** **Denominator:** Number of unique patients with at least one medication in their medication list seen by the EP during the EHR reporting period **NOTE: Answer is required if Exclusion does not apply to you.**	**Numerator** IF answer No to exclusion, the numerator = If answered Yes, not needed	**Denominator** IF answer No to exclusion, the denominator = If answered Yes, not needed	**Exclusion** Yes or No	**Y/N**	

Figure 1 – Example of Workbook page

3. Required Supporting Documentation

CMS and BMS recommends documentation is retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of five years, or three years after audits, with any and all exceptions having been declared resolved by BMS or the U.S. Department of Health and Human Services (DHHS).

The provider must make all records and documentation available upon request to BMS and/or DHHS. Such records and documentation must include but not be limited to:

- ❑ Financial Records
- ❑ Practicing Provider Information (credentials)
- ❑ Identification of Service Sites
- ❑ Dates of Service for Each Service Component by Patient
- ❑ Patient Records
- ❑ Invoices/lease agreement supporting Adopt/Implementation/Utilization(AIU)
- ❑ EMR Reports supporting Meaningful Use attestation

OUT OF STATE DOCUMENTATION

If the provider plans to include encounter counts from another payer's state, the following documentation is required in an electronic format (pdf, Microsoft Word or Excel, or jpeg) and will need to be included with the electronic attestation. This is optional.

- ❑ Certification on official letterhead from the state Medicaid agency declaring the numbers obtained were derived from the state's MMIS and are accurate.
- ❑ Report generated by the State Medicaid agency with the total Fee-for-Service and Managed Care Organization encounter count and reporting period.

Please review the BMS requirements and applicable provider manuals for the specific service requirements, retention periods, and lists.

4. Obtaining an West Virginia (WV) Medicaid Management Information System (WVMMIS) Login

WV Medicaid providers must first have an account in West Virginia Provider Web portal www.wvmmis.com in order to gain access to the WV Provider Incentive payment system.

To sign up for a login and password to the West Virginia Health PAS Online Provider portal, a Medicaid enrolled provider must visit https://www.wvmmis.com/TradingPartnerRegistration.aspx or contact WV Medicaid Provider Services staff at 1-888-483-0793 or via email at wvmmis@molinahealthcare.com.

5. Determine If Intend to Use Group/Clinic Medicaid Volume to Meet Medicaid Volume Requirements

Providers may elect to use group practice or clinic locations encounter to achieve the 30% Medicaid volume requirement for incentive payment. If the provider elects to use the group or clinic total (as the proxy for encounter volume), all providers within that practice or location must also do so if they intend to attest for incentive payment, and report their volume using the practice or clinic NPI accordingly.

EPs may use a clinic or group practice's patient volume as a proxy under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
2. There is an auditable data source to support the clinic's patient volume determination;
3. So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

6. Finding EHR Certification Number

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) tests and certifies electronic medical record (EHR) systems. If the EHR system is approved, it is assigned a certification number. The website below is the Certified Health IT Product List website to look up EHR certification number or even to register an EHR http://onc-chpl.force.com/ehrcert.

Figure 2 – Certified Health IT Product List window

7. System Requirements

To successfully use all features of the Provider Incentive Program (WV EHR Incentive Program), ensure that the computer system meets the following minimum requirements:

- PC has a reliable internet connection
- Web browser – The latest version of Microsoft® Internet Explorer is recommended (IE7.0 and higher). As versions of Internet Explorer become available it is recommended that these versions are used
- Adobe® Acrobat Reader

8. Navigation

This section describes all of the different navigation options that are available throughout the application.

8.1 Breadcrumbs

When a hyperlink is clicked, the appropriate web page is displayed to the right of the navigation bar. The breadcrumbs indicate the current position within the site. Breadcrumbs are a visual representation of pages and sub-pages followed to reach this page. Select the underlined name to return to the specific page. For the example screen, the breadcrumb translates to the following:

- The Meaningful Use Core Measures gray text that is not underlined in the breadcrumb indicates the current section. In this case it is the Meaningful Core Measures questions.
- The underlined text will display the page that it is assigned. For example:
    - Attest displays the Reason for Attestation page.
    - Attestations displays the Attestation Instructions page.

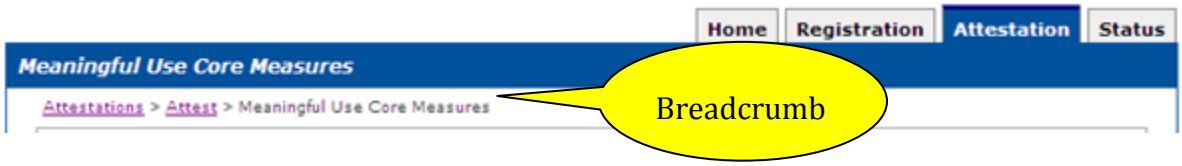


Figure 3 - Breadcrumbs

8.2 Use of the Navigation Features

Every window of the WV EHR Incentive Program has a set of standard navigation features. The features are located on the upper right-hand corner of the application. Refer to Figure 4.

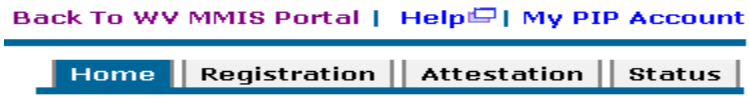


Figure 4 – Feature Description

8.2.1 Help Hyperlink

- The Meaningful Use questions provide a Help link. When selected, the CMS specifications for the question displays in a separate Internet Explorer window. An example of the link is below:

For additional information: Clinical Quality Measure Specification Page

8.2.2 WV EHR Incentive Program Account Hyperlink

- Displays a screen with an email address box. WV EHR Incentive Program will use this email address to send notifications regarding the attestations. You may enter a new address, or update an existing one. Save changes by selecting the Update button. Press the Cancel button and changes will not be saved.

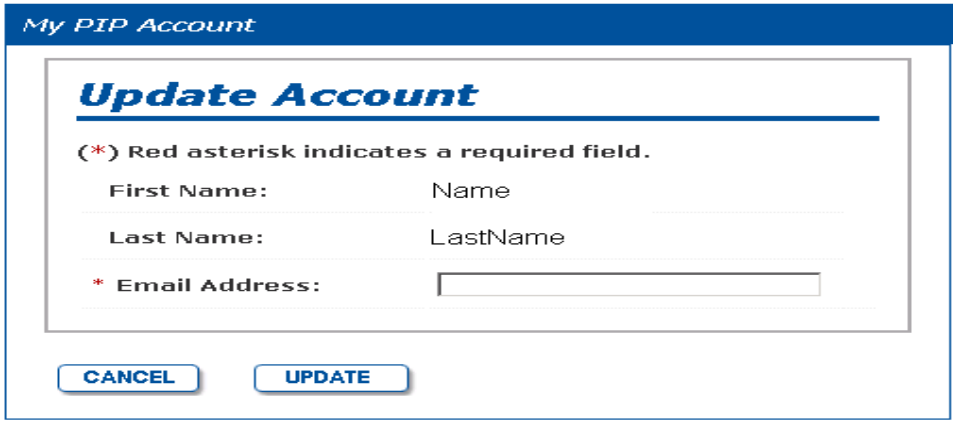


Figure 5 – Update Account Screen

8.2.3 Back to WV MMIS Portal

- Displays the WV MMIS Portal Welcome screen. Refer to Figure 12, WV Welcome Screen.

8.2.4 Home Tab

- The Home tab displays the Home page. Refer to Figure 6.

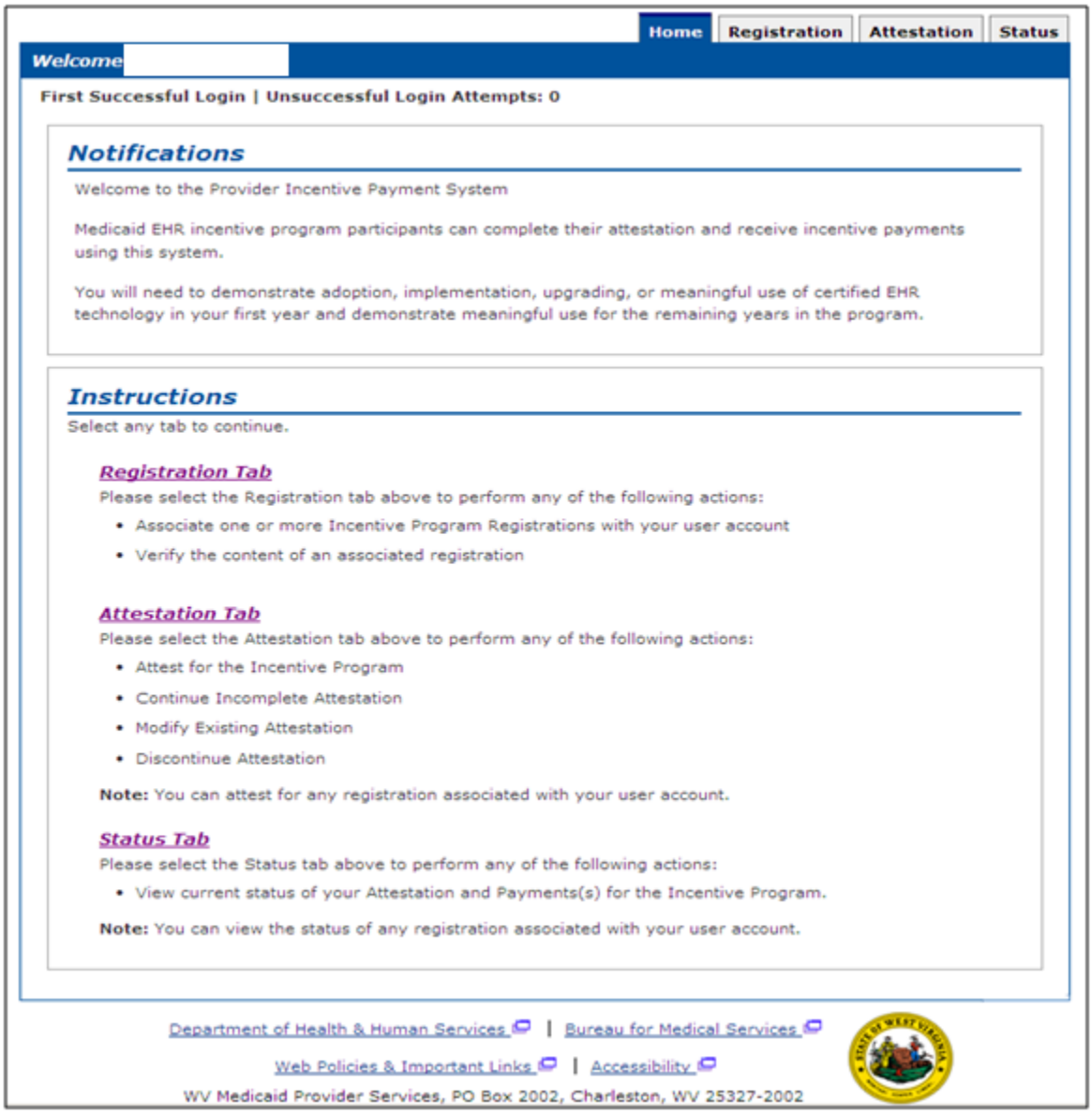


Figure 6 – Home page

8.2.5 Registration Tab

The Registration tab displays the registration instruction window. Refer to Figure 7.

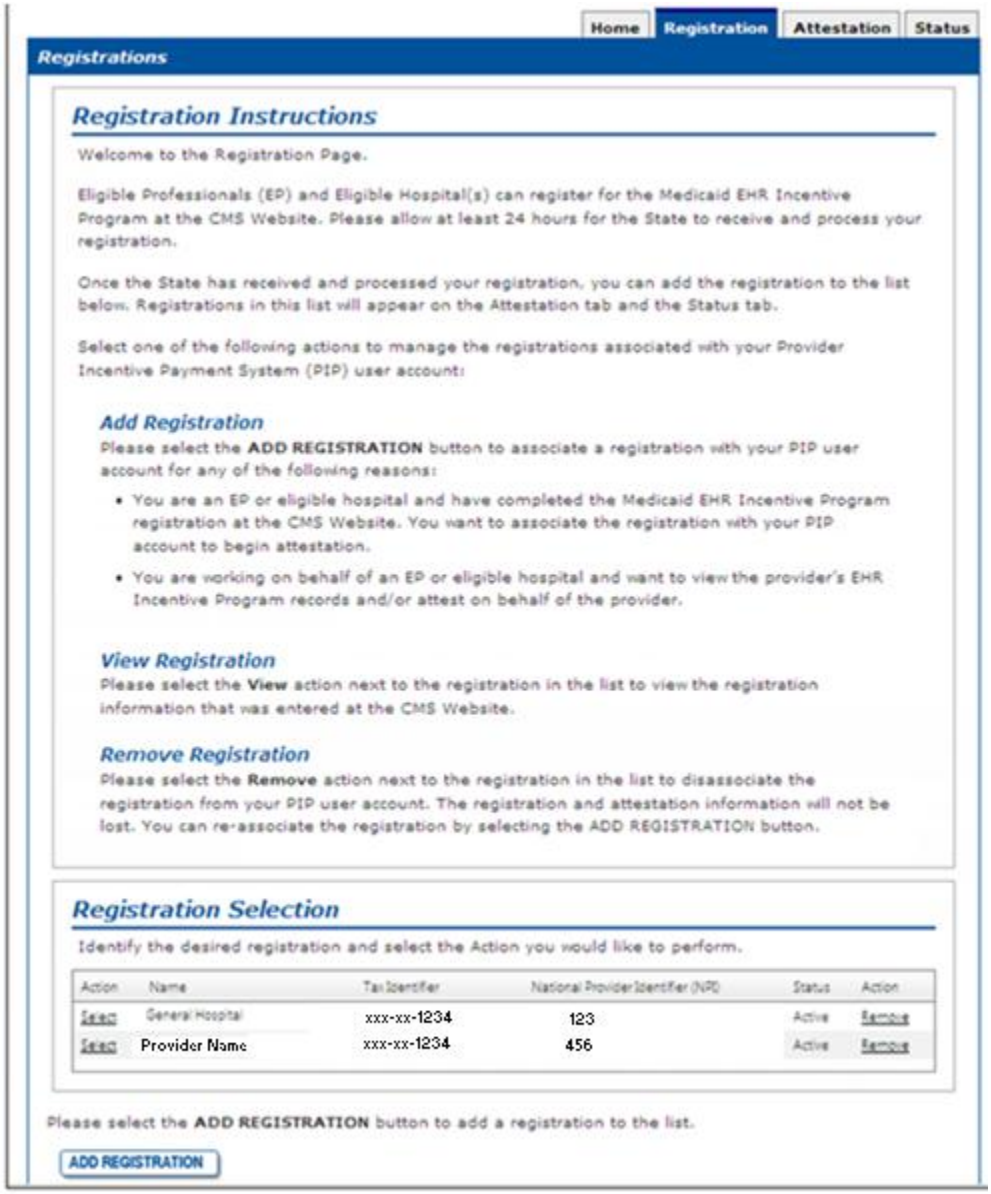


Figure 7 – Registration Window

8.2.6 Attestation Tab

The Attestation tab displays the Attestation home page. Refer to Figure 8.

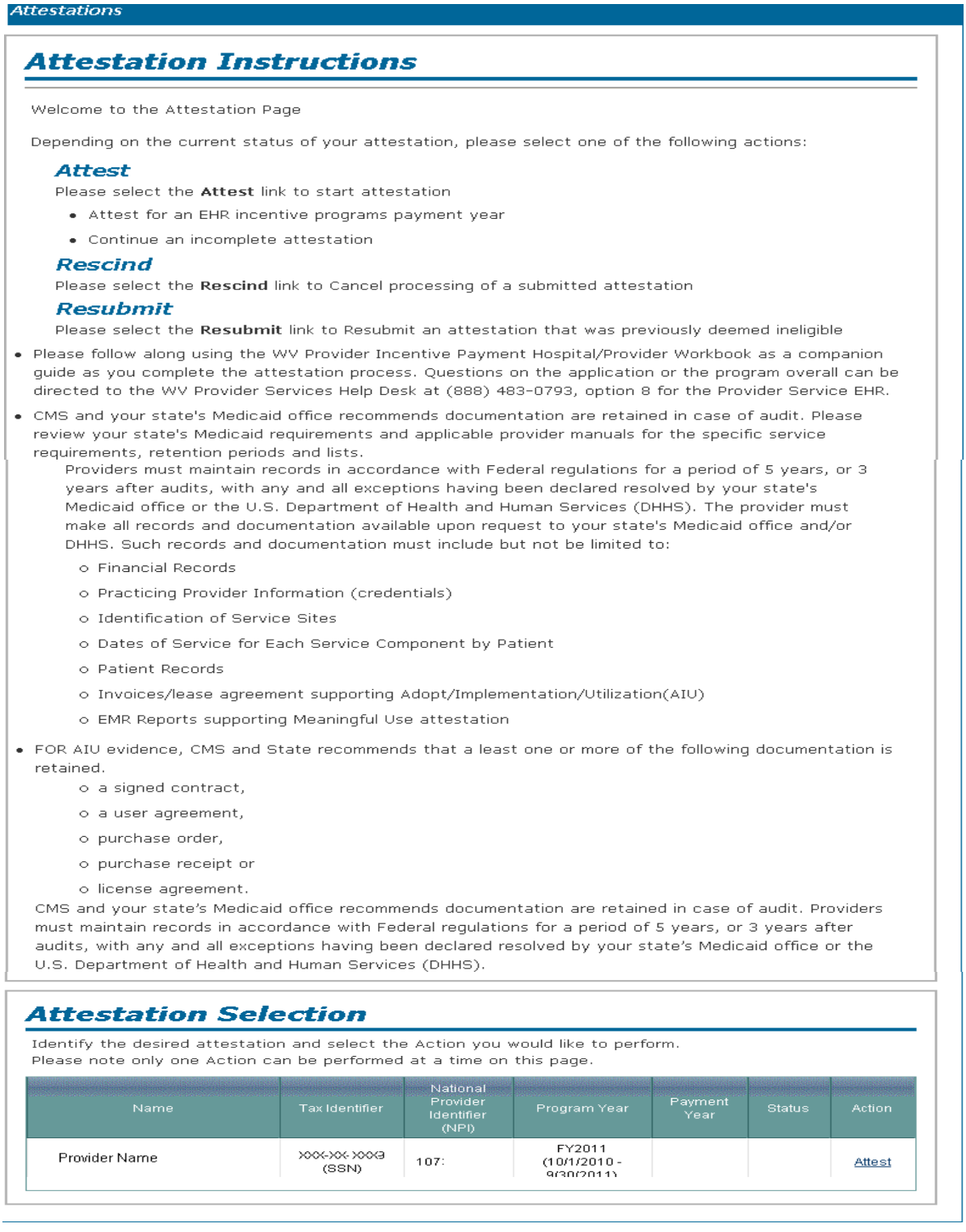


Figure 8 – Attestation Tab

8.2.7 The Standard Buttons

There are certain buttons found below the fields of each functional window that enables certain actions. The available actions depend on the purpose of the window. The most common buttons associated with WV EHR Incentive Payment Program are the Previous Page and the Save and Continue buttons. The Previous Page button displays the previous page in page sequence. The Save and Continue button must be selected after information is entered. If not, any entries in the window are lost and must be re-entered. The Submit button is also an option and is used when the user is ready to submit the answers for review and possible payment. Refer to Figure 9.

Figure 9 – Standard Buttons

9. Using the WV EHR Incentive Program Application

The WV EHR Incentive Program application guides the user through the CMS required questions to determine if a provider is eligible to receive provider incentive payments. A workbook that contains the questions and the rules outlined by CMS is available and provides areas where answers may be recorded. A provider may enter the information or assign someone to enter the information on their behalf.

The list below contains the different sections. Each section is discussed in detail.

- Pre-eligibility checks, which is executed on the receipt of a registration ID from CMS
- Log into the WV EHR Incentives instructions
- How to Register a provider
- Entry of Eligibility responses
  - Respond to practice setting
  - Respond with Medicaid volume and determine if the amount is accurate. If not, then determine if certain criteria are met
- Payment Schedule
- Entry of CMS EHR information
- Submit Attestation

The figure below is a pictorial view of the WV EHR Incentive Program application steps.

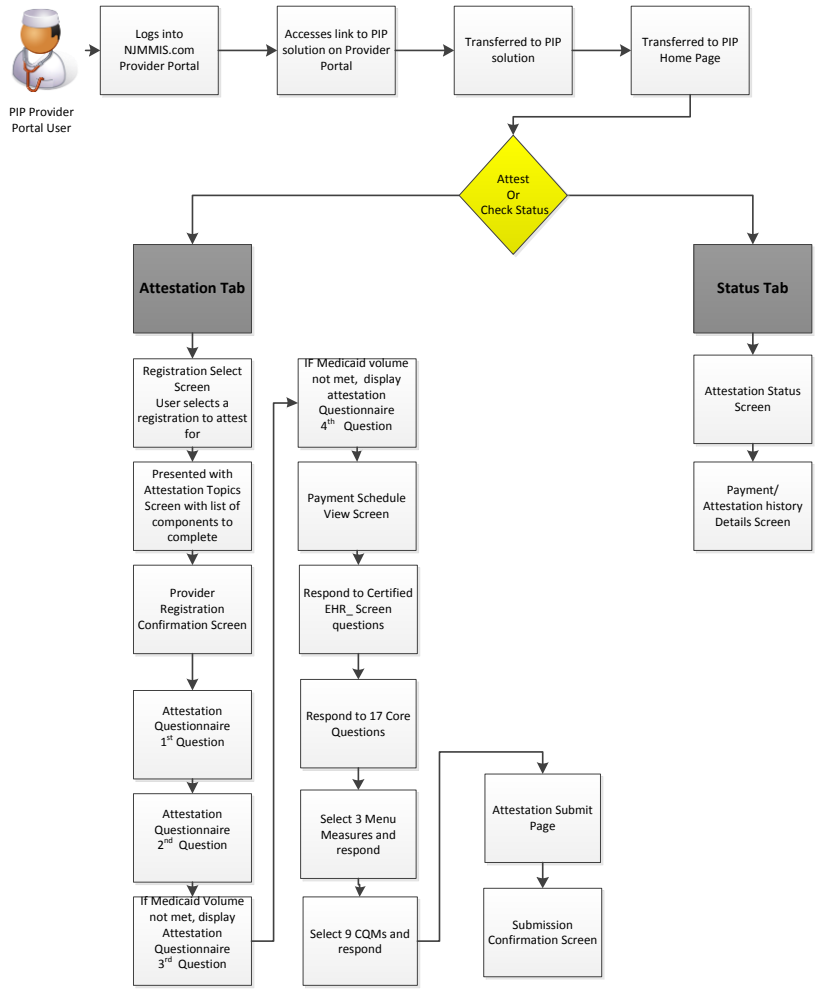


Figure 10 – Attestation Flowchart

9.1 Login to the WV EHR Incentive Solution

This section provides instructions on how to start the WV EHR Incentive Solution application and logging into the system to use the application. Please obtain authorization from the registering provider to enter the data on their behalf.

9.1.1 Starting WV EHR Incentive Program Application

The application runs on the Internet. Execute the following steps to start the application.

1. Access the www.wvmmis.com main page. As shown in the figure below:

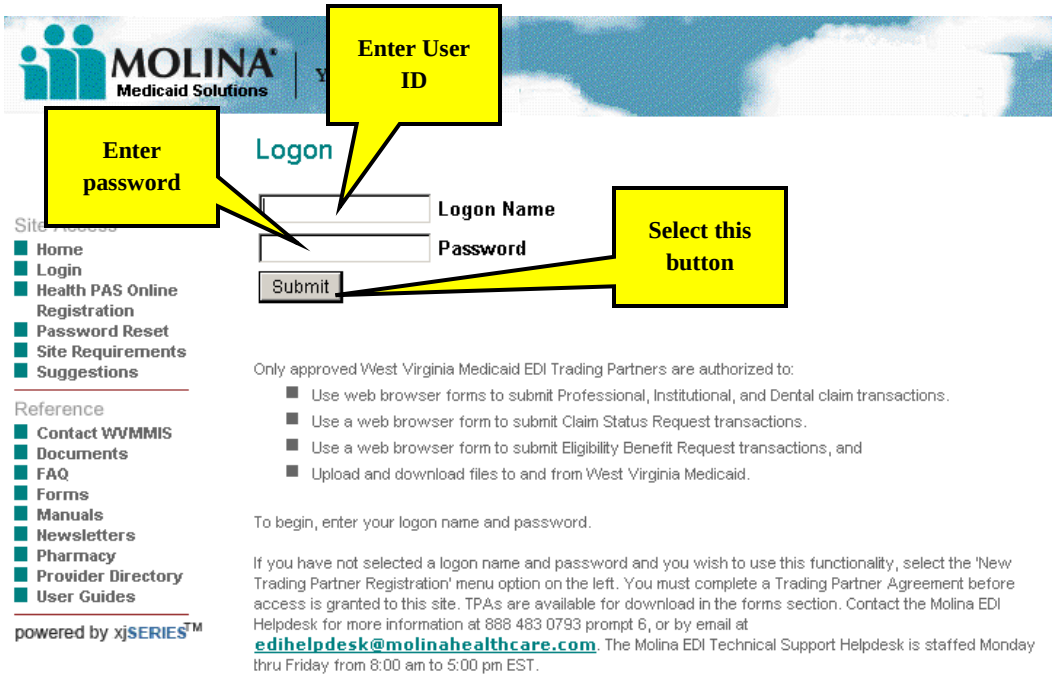


Figure 11 – WV Login Screen

2. Prepare to Logon by entering in Logon Name and Password in the appropriate entry boxes and select Submit
    - Enter Provider Web portal user ID
    - Enter Provider Web portal password
    - Select Submit button
3. On the **Welcome** window, select the **WV EHR Incentive Program** option to display the **Provider Incentive Program About This Site** window. Refer to Figure 13.

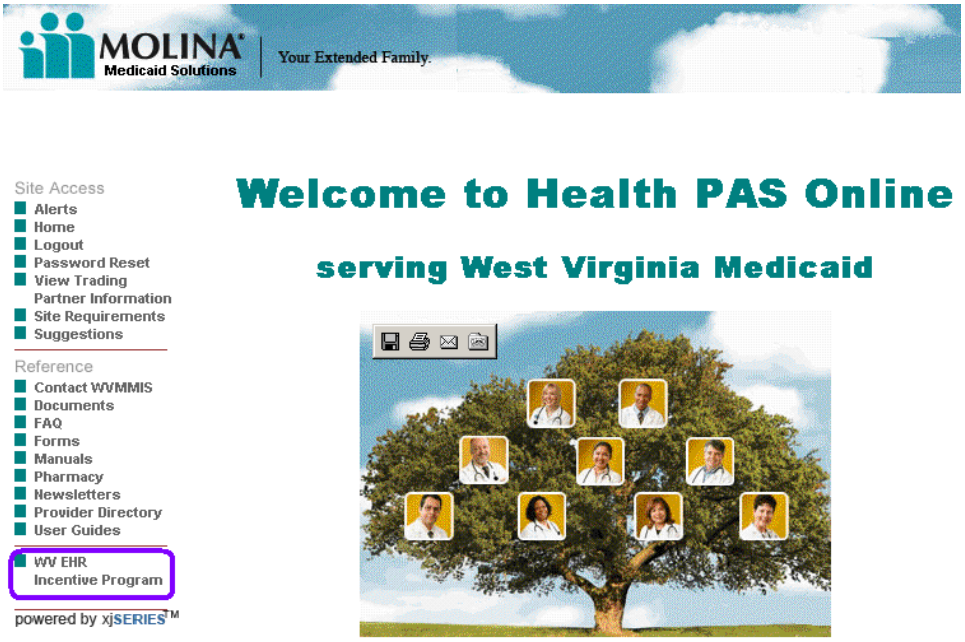


Figure 12 – WV Welcome Screen

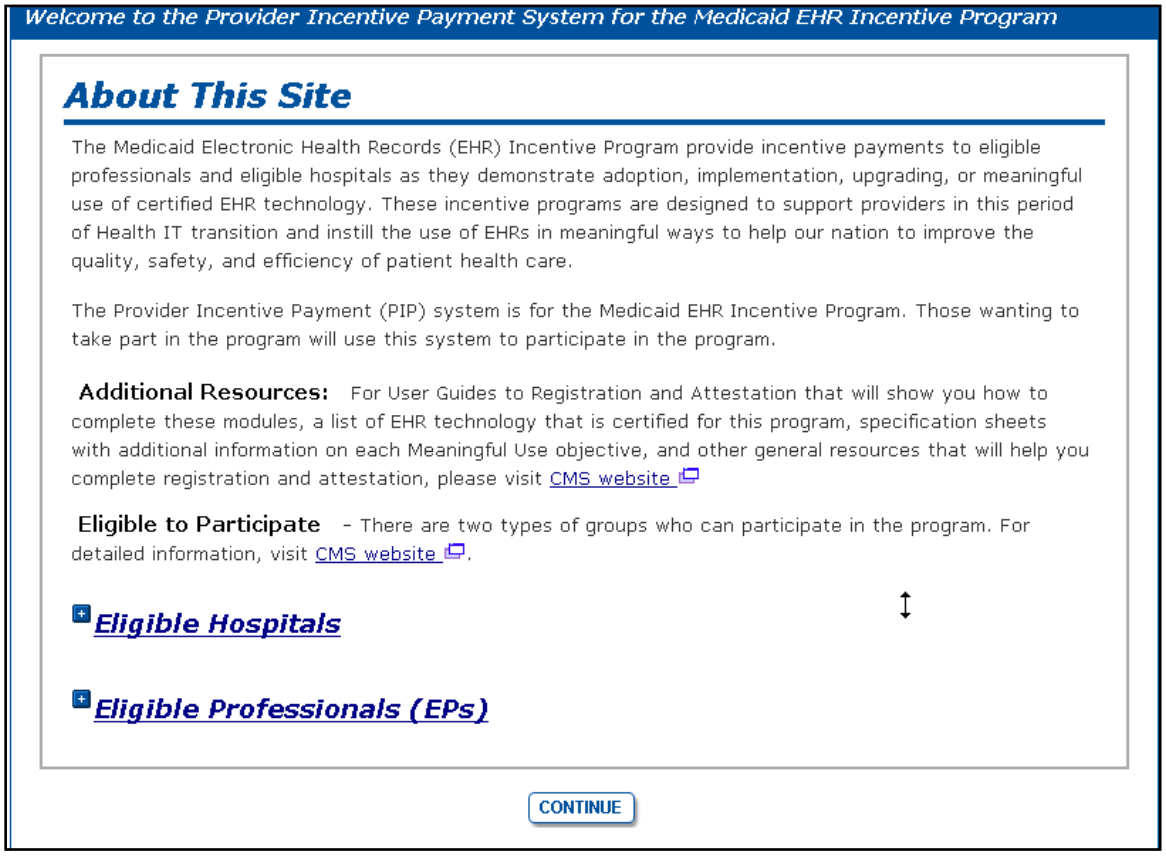


Figure 13 – Provider Incentive About this Site Page

4. On the **Provider Incentive About This Site** window, select the **Continue** button to display the **Provider Incentive Program Notifications** window. Refer to Figure 14.

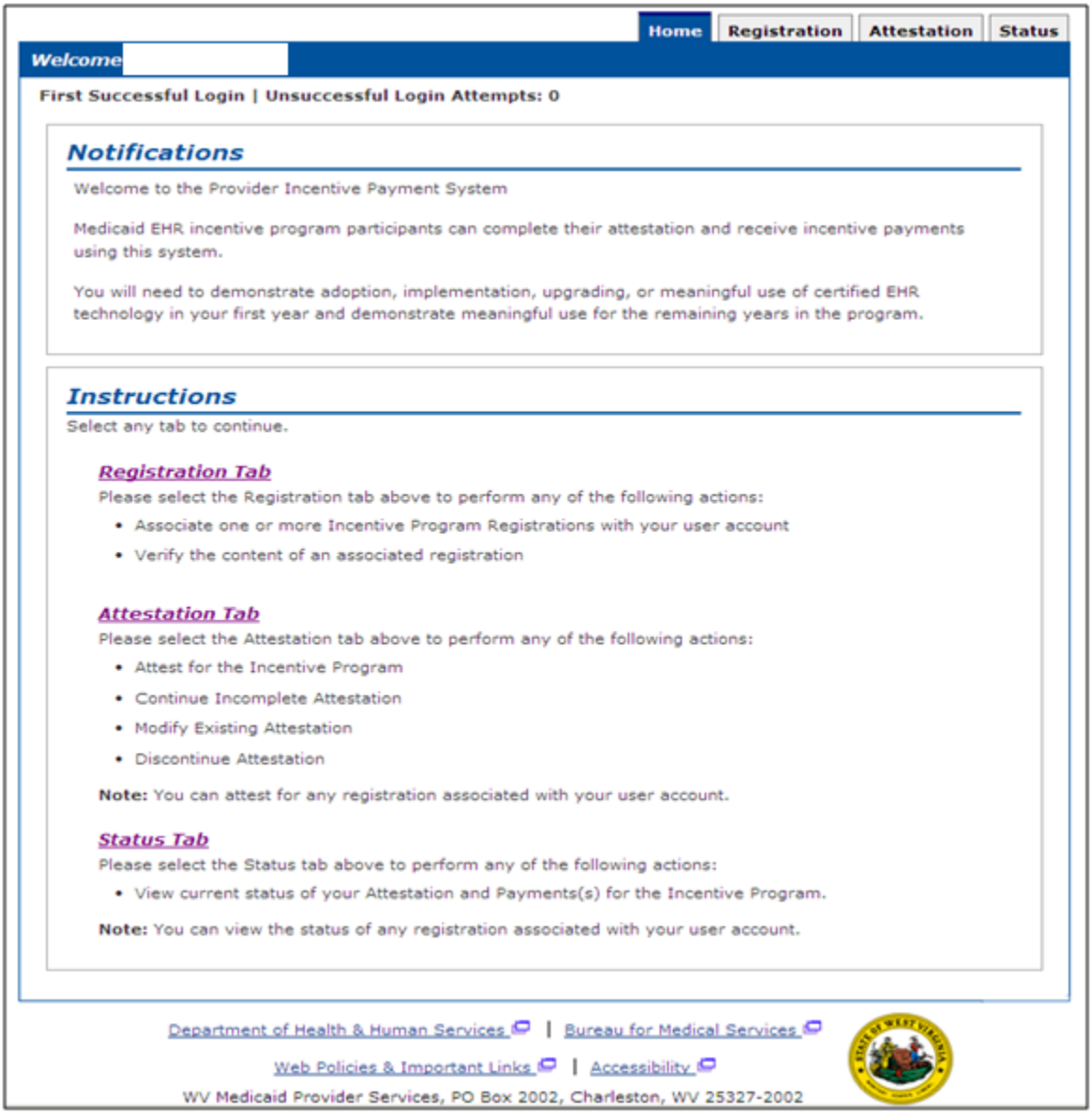


Figure 14 – Home Page

9.2 Registering a Provider within WV EHR Incentive Program

The registration process is used to associate the CMS registration with the West Virginia EHR Incentive Program attestation. For Stage 2, the following bulleted items are different scenarios and indicate if the registration process is executed.

- If you have submitted prior attestation and are eligible for Stage 2, you do not need to register. Your attestation will be ready when the Stage 2 attestation is opened in the WV EHR Provider Incentive Program application. Use the attestation tab.
- If you have not submitted any attestations, you are not eligible for Stage 2 Meaningful Use stage. Please use the appropriate manual for your payment year.
- If you are a new user to submit on behalf of a provider who is eligible for Stage 2, you will need to register and follow the Add Registration instructions. Please ensure that you have the provider's permission to attest on his behalf.
- If provider's information has changed, you may need to update CMS information on the CMS registration page. Be sure to submit or complete the action on the CMS page. This includes the action of reviewing the information on the CMS page. If you do not submit or complete, this will stop your attestation from processing.

The Register tab associates one or more provider registrations to a user ID, view registration IDs that are attached to a user ID, and removes any provider registrations. Please obtain authorization with the provider to enter the data on their behalf.

1. To view, add, and remove registrations, click the **Registration** tab on the navigation bar.

Figure 15 – Registration tab

2. The Registration home page displays. Refer to Figure 16.

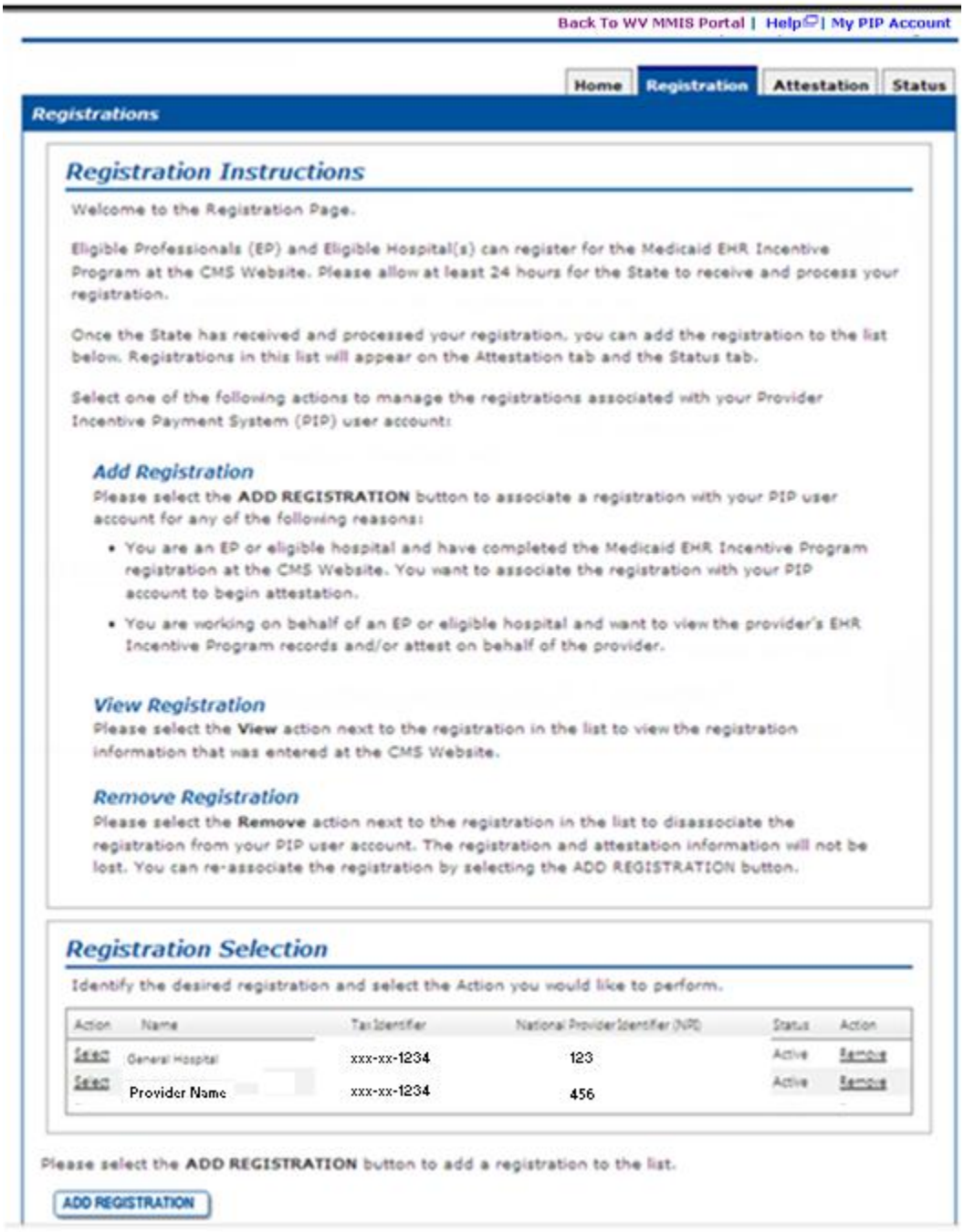


Figure 16 –Registration Tab - Registration Home Page

3. The Registration home page lists all registrations that you have added. If you have not added any, the Registration Selection section will display "No records to display" as shown in the figure below.

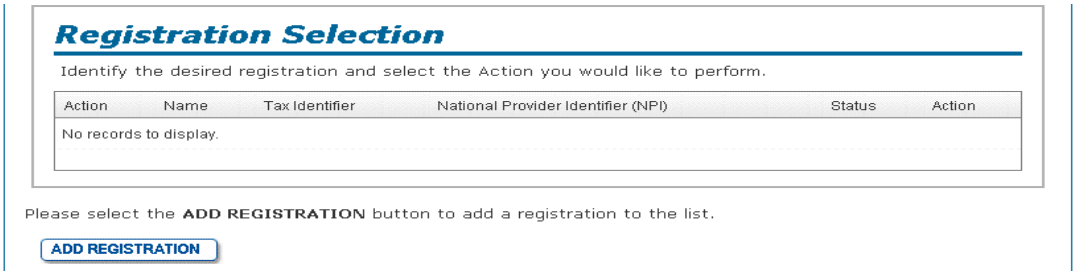


Figure 17 –Registration Tab– No Records to Display

4. The registration sections below explains the options that are available on the Registration home page, which are Add Registration, Select, and Remove.

9.2.1 Registration – Add option

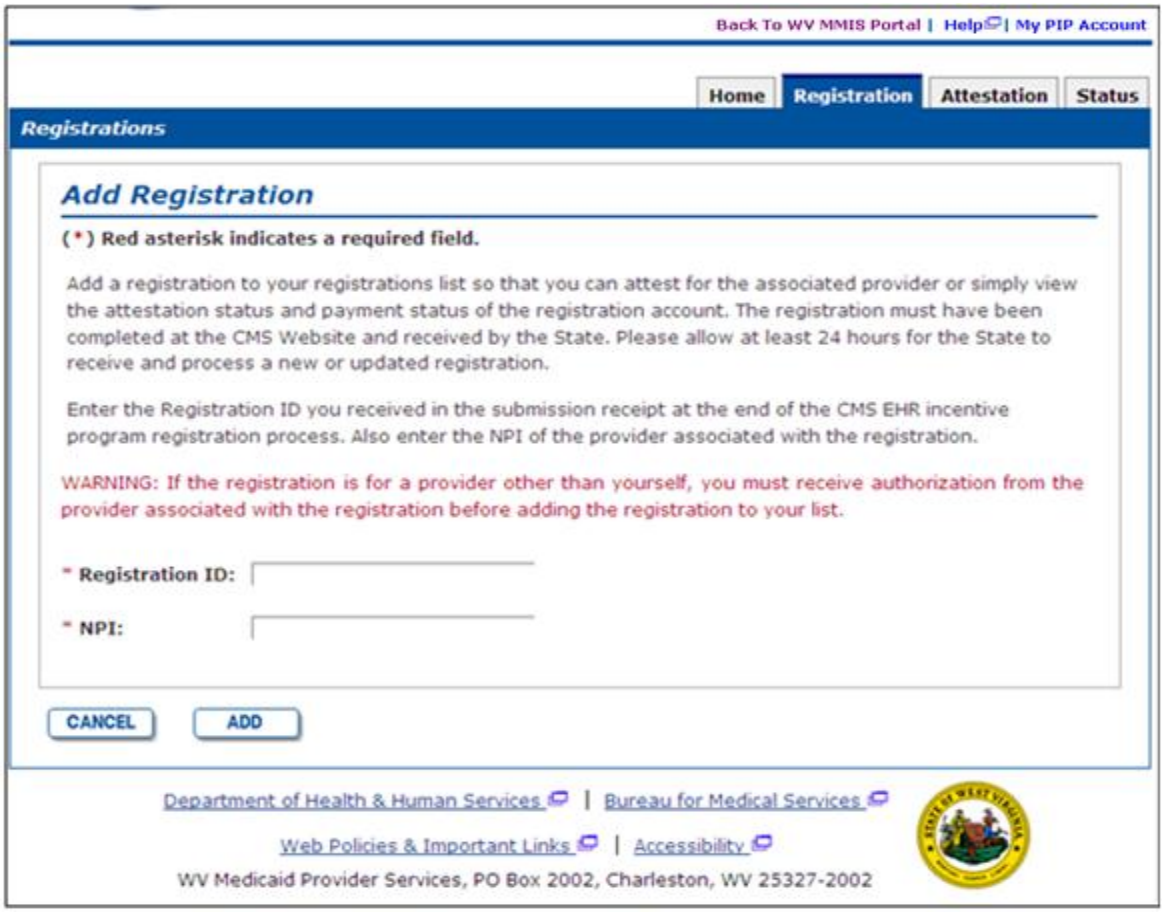


Figure 18 – Registration Tab – Add Registration

5. Click the **Add Registration** button on the **Registration** home page.
6. Enter registration ID obtained from the CMS website.
7. Enter the provider's NPI.
8. Click the **Add** button.
9. The system validates that the registration ID is a valid ID assigned by CMS and that the correct NPI was entered.
10. If valid, the registration ID and NPI is associated with the user ID. The Registration Information window displays with the registration information that was entered. Refer to Figure 19.

11. The **Previous Page** button returns to the **Registration** home page.

Figure 19 – Registration Tab - Registration Information Window

If invalid, an error message displays. The Add Registration page continues to display until the information is entered correctly or a navigation option is selected.

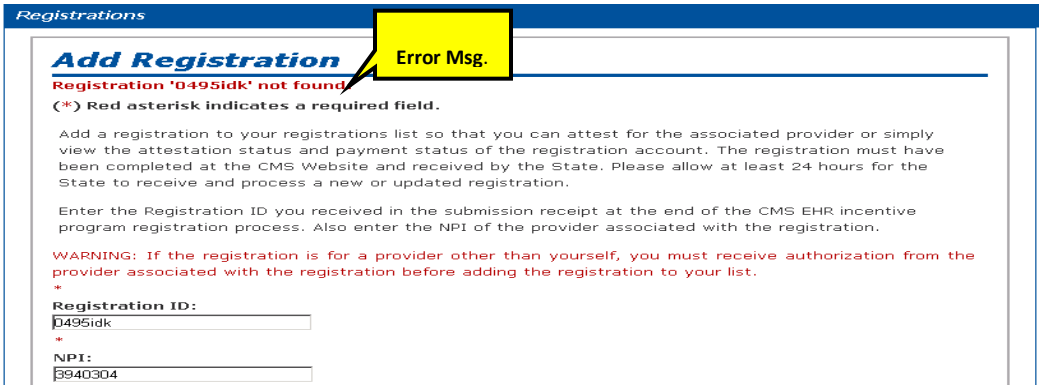


Figure 20 – Add Registration Error Message

The most common reasons why an error occurs:

- Information entered incorrectly.
- If necessary, access the CMS website to check the information or add a registration.
- The registration ID will not be found if 48 hours has not expired after registering on the CMS web site.

The Cancel button is an additional option that is available. Clicking the Cancel button does not add the registration ID and the Registration home page displays. No additional registration ID displays.

9.2.2 Registration – Select Option

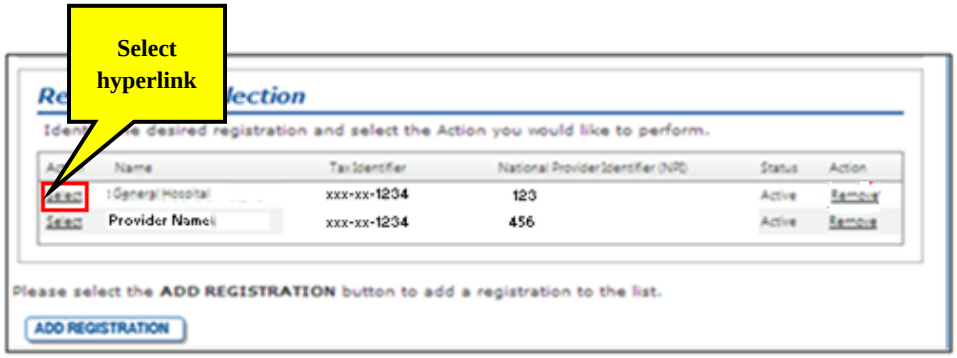


Figure 21 – Registration Tab - Registration Information Window

Click the **Select** hyperlink and the registration details displays for the registration ID selected. Refer to Figure 21.

9.2.3 Registration – Remove Option

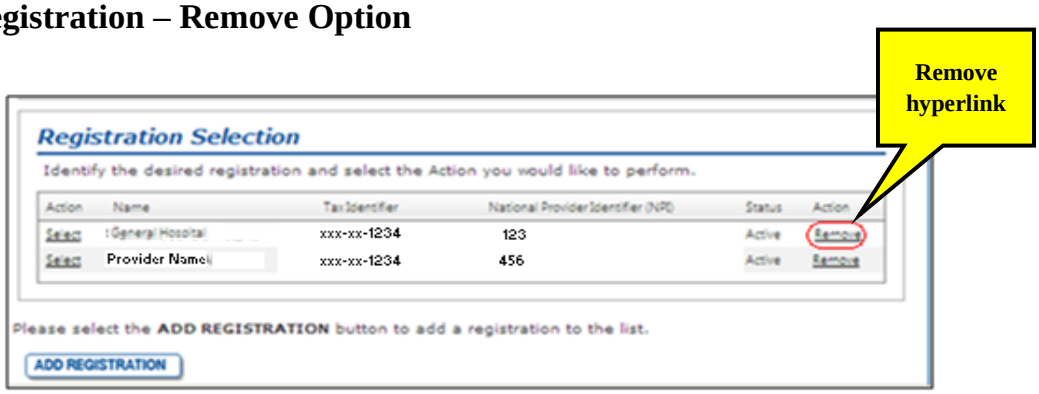


Figure 22 – Registration Tab – Remove Option

The Remove hyperlink next to a registration ID removes the registration ID from the user ID. The registration ID no longer displays in the registration and in the Attestation window. Refer to Figure 22.

The registration ID is still available for the user to reassign by executing the add registration steps. The data that was entered is saved. **NOTE:** If someone else registered to attest for the provider, the data that was entered by this user will display.

9.3 Attestation

The provider will select the registration and continue with populating the provider's attestation for that year. The solution will walk the eligible provider through a series of Incentive Attestation screens that directly relate to the provider workbook the State has provided to assist the provider with completing attestation. The provider must complete these questions in order to proceed with submitting the attestation and potentially receiving payment.

The workbook provides the answers that will be entered in the appropriate screen so that the provider is prepared to answer all related questions prior to beginning the attestation process.

The Attestation workflow consists of the following topics. The application will guide the user through the topics. A topic does not become active until the prerequisite topic is completed. Each topic will be addressed.

- Verify Registration Information
  - Verify the provider information is the correct provider.
  - Ability to indicate proxy usage.
- Eligibility Screens
  - These screens walk the provider through the attestation specific eligibility questions that they must complete in order to be validated as an eligible provider for the Incentive Program.
    - These screens include:
      - Questions on provider practice location
      - Questions on provider Medicaid volume
- Payment Screens
  - These screens walk the provider through the expected payment schedule and questions related.
- Certified EHR Technology
  - This screen validates that the provider is indeed using a valid EHR solution for the purposes of supporting Meaningful Use in Years 2-6.
- Meaningful Use Core
  - There are 17 required core objectives that the user is required to answer.

- Meaningful Use Menu Measures
  - A minimum selection of three objectives is chosen from the list of six menu measures objectives.
- Clinical Quality Measures
  - A minimum selection of nine from the list of 64 clinical quality measures.

To access the Attestation process, select the Attestation Tab.

Figure 23– Attestation Tab

When selected, the Attestation Instructions page displays. This page displays the registration ID's that are assigned to the user.

The user does not need to complete the Attestation process in one sitting. Each screen in the Attestation flow has a Save and Continue button. This will save changes and allow the user to stop at any time without the loss of data that has been entered on that page. The attestation process does not allow the user to skip forward to screens or jump past a screen without entering data. The user may edit answers until the attestation is submitted.

To start the attestation process:

1. Select the Attestation option on the row for the Registration information.

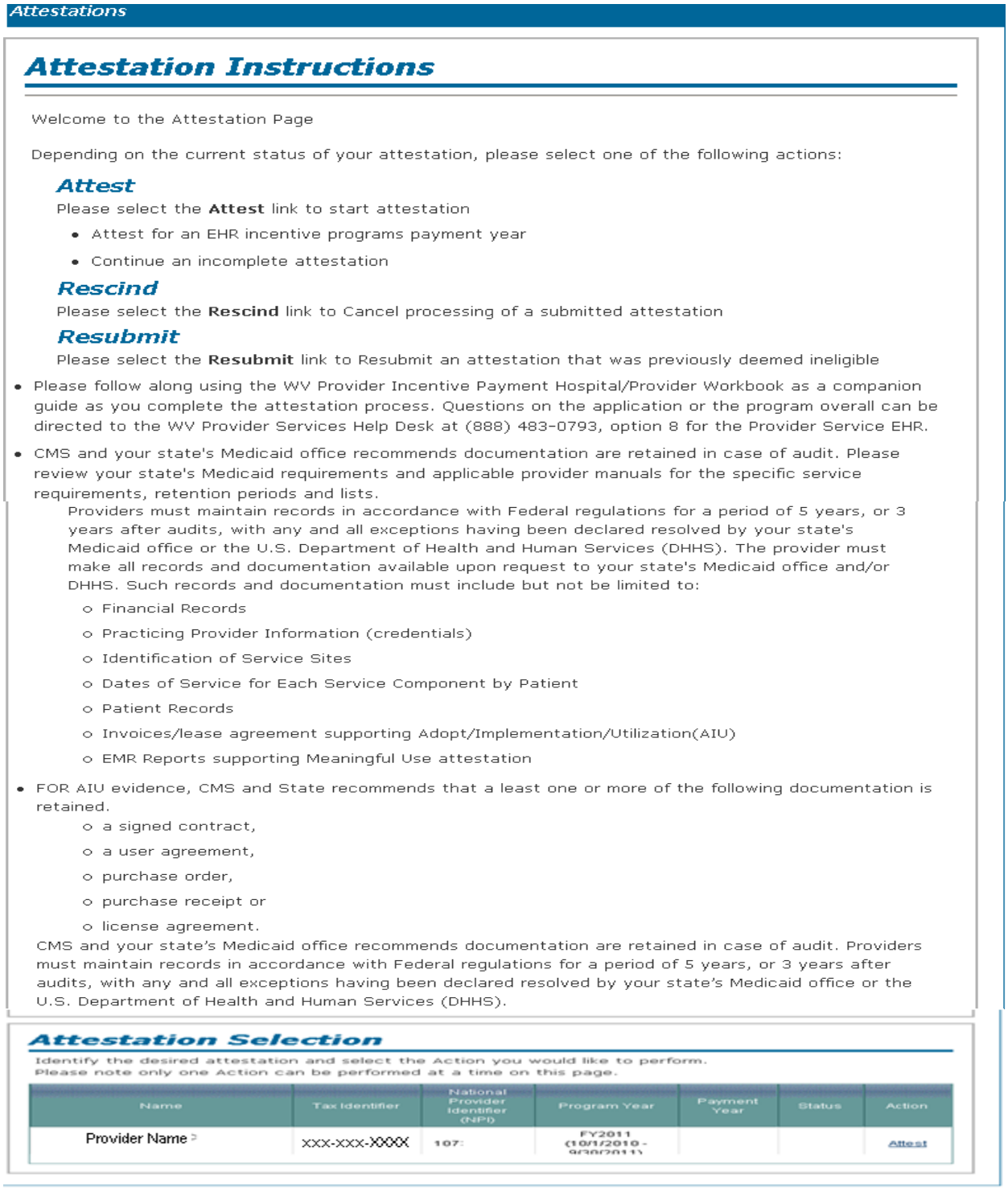


Figure 24 – Attestations Tab – Attestation Selection

2. Review the Attestation status displayed on the Attestation Topics Page. If the provider is not listed, please select the Status tab. The Status tab will display the current attestation. Locate the provider in the list to see the error that prevented the provider from executing the attestation process.
3. The topics available on this page are as follows:

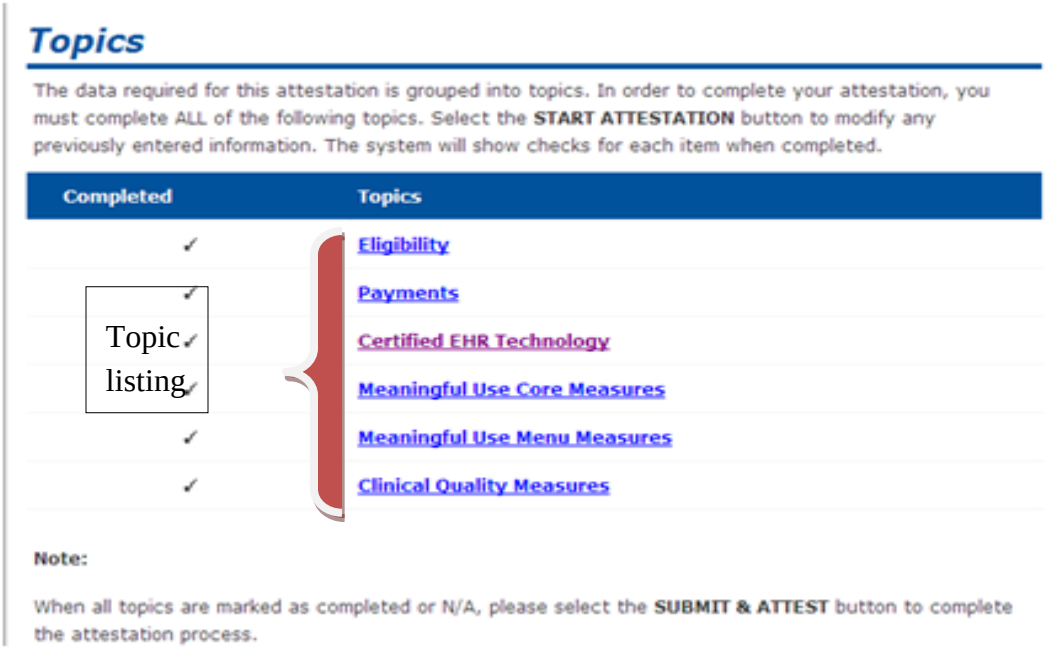


Figure 25 – Attestation Tab - Attestation Topic Listing

- ❖ The topic listing identifies the completed topic by placing an indicator next to the topic. A topic is completed when the required answers are entered and saved.
- ❖ Topics become available as prerequisite topics are completed.

4. Select the Start Attestation button to start the attestation process or to continue to add and modify data already entered.
5. Select the Submit & Attest button when satisfied with the data that is entered. This submits the responses to determine eligibility for payment processing. The responses are also available to be reviewed by the State.

- ❖ The Submit & Attest button is disabled on the initial selection of a registration ID.
- ❖ The Submit & Attest button is disabled if the Eligibility check was set to Ineligible.

6. Select the Previous page button to display the Attestation Instructions page.
7. On selection of the Start Attestation button, the Registration Information will display.

Figure 26 – Attestation Tab – Verify Registration

- Select Medicaid ID
    - Purpose: if provider matches on more than one Medicaid ID, the provider may select which Medicaid ID attesting to or wishing to pay.
    - Displays the NLR submitted NPI number's matching Medicaid IDs for the payee that was registered for, along with their active Medicaid ID enrollment dates**.**
    - Please note that the provider does not have to be an actively enrolled in Medicaid to be paid. The provider needs to have a pay to affiliation active at the time of the attestation period submitted for volume and Meaningful Use.
    - Dropdown box displays the Medicaid IDs. Select drop down box option to display the Medicaid IDs that were found. Highlight the desired ID and click mouse to select.
- Select Payee Medicaid ID
    - Select the Medicaid ID that will be used for payment. A provider may have one-to-many Medicaid IDs on file matching to the provider's single NPI on record. The designated NPI for payee should be matched to the corresponding Medicaid ID that the provider wishes to have the payment sent to ensure the appropriate match to the local Medicaid payee affiliation records.
    - Dropdown box displays the Medicaid IDs. Select drop down box to display the Medicaid IDs that were found.
- Select election to use Provider Proxy

Please enter the election to use the provider proxy usage for Medicaid Volume. Please remember that the following criteria must be met.

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- There is an auditable data source to support the clinic's patient volume determination;

- The practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works both in the clinic and outside the clinic (or with and outside a group practice), the clinic/practice level determination includes only those encounters associated with the clinic/practice.

1. Select Yes or No
2. If selected Yes, enter organization's NPI number.
3. Select Save and Continue button.

9.3.1 Attestation Eligibility

The purpose of the Attestation Eligibility section is to determine if the practice setting and Medicaid thresholds are met. In order to be eligible for the Medicaid EHR Incentive Program, eligible professionals (EPs) must meet eligible patient volume thresholds. For most professionals, this means a 30% eligible patient volume based on total patient encounters. For most EPs, eligible patient volume only includes Medicaid encounters; however, EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria; as described in the details below.

Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20% instead of 30%). If pediatricians have greater than 20%, but less than a 30% eligible patient volume, their annual incentive cap is reduced to 2/3. Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount they qualify for.

WV EHR Incentive Program defines an encounter as "One or more claims for the same patient for the same rendering physician for the same date of service (DOS). This should be a count of unduplicated per patient, per DOS Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services. The West Virginia EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count within the numerator."

9.3.1.1 Encounter Calculation

For purposes of calculating EP eligible patient volume, a Medicaid encounter as defined by the WV EHR Incentive Program as "An encounter should be reflected in the count as one or more claims for the same patient for the same rendering physician for the same DOS. This should be a count of unduplicated per patient, per DOS Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services. The West Virginia EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count within the numerator." In other words, Eligible Professionals should count the following as one patient encounter: One-to-many claims for the same patient where the claim has the same DOS and the same rendering/attending provider. All claims related to the actual "encounter" with the patient for the same date and same provider.

9.3.1.2 Eligibility Screen 1 – Service Setting

To determine if the majority of services were hospital-based; evaluate if 90% or more of services were performed in a hospital inpatient or emergency room setting. The following section aids in this process:

Figure 27 – Attestation Tab – Service Setting

8. Select YES if hospital-based, then select Save and Continue button.

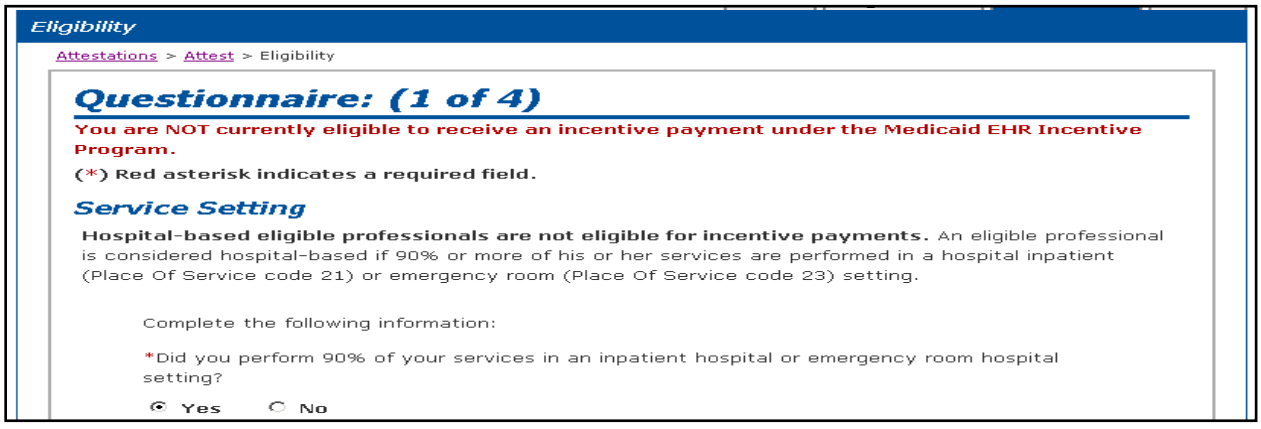


Figure 28 – Attestation Tab - Eligibility Window

✍ *Hospital-based providers are not eligible to receive the payments.*

✍ *The application will display an error message, "You are NOT currently eligible to receive an incentive payment under the Medicaid EHR Incentive Program." The Attestation Process is halted and the user will not be allowed to continue entering in information. The eligibility status is set to Ineligible.*

9. Select NO if the provider is NOT hospital-based and select Save and Continue button.
   - ❖ The application will continue to the Eligibility Screen 2 – Volume Check question.
10. Select Previous Page button to display the Verify Registration page.

✍ *Regardless of the answer, after attestation submission and finalization (48hrs after submittal) the system will validate the provider's attestation and that they practice predominately outside a hospital by checking the place of service for the attesting provider's or the proxy's claims for the period specified within the system to validate Medicaid volume. If the providers are performing encounters in an inpatient or emergency room setting, the solution will PEND the attestation for further review. The Provider may then contact the Provider Services Help desk to review their attestation and work the PEND. The user will not be able to continue entering attestation data.*

9.3.1.3 Eligibility Screen 2 – Volume Check

The purpose of this screen is to determine if the volume in the practice is eligible for the incentives.

In order to be eligible for the Medicaid EHR Incentive Program,

- ❑ Eligible professionals (EPs) must meet eligible patient volume thresholds. For most professionals, this means a 30% eligible patient volume based on total patient encounters for the Attestation period.
- ❑ Pediatricians for the Attestation period

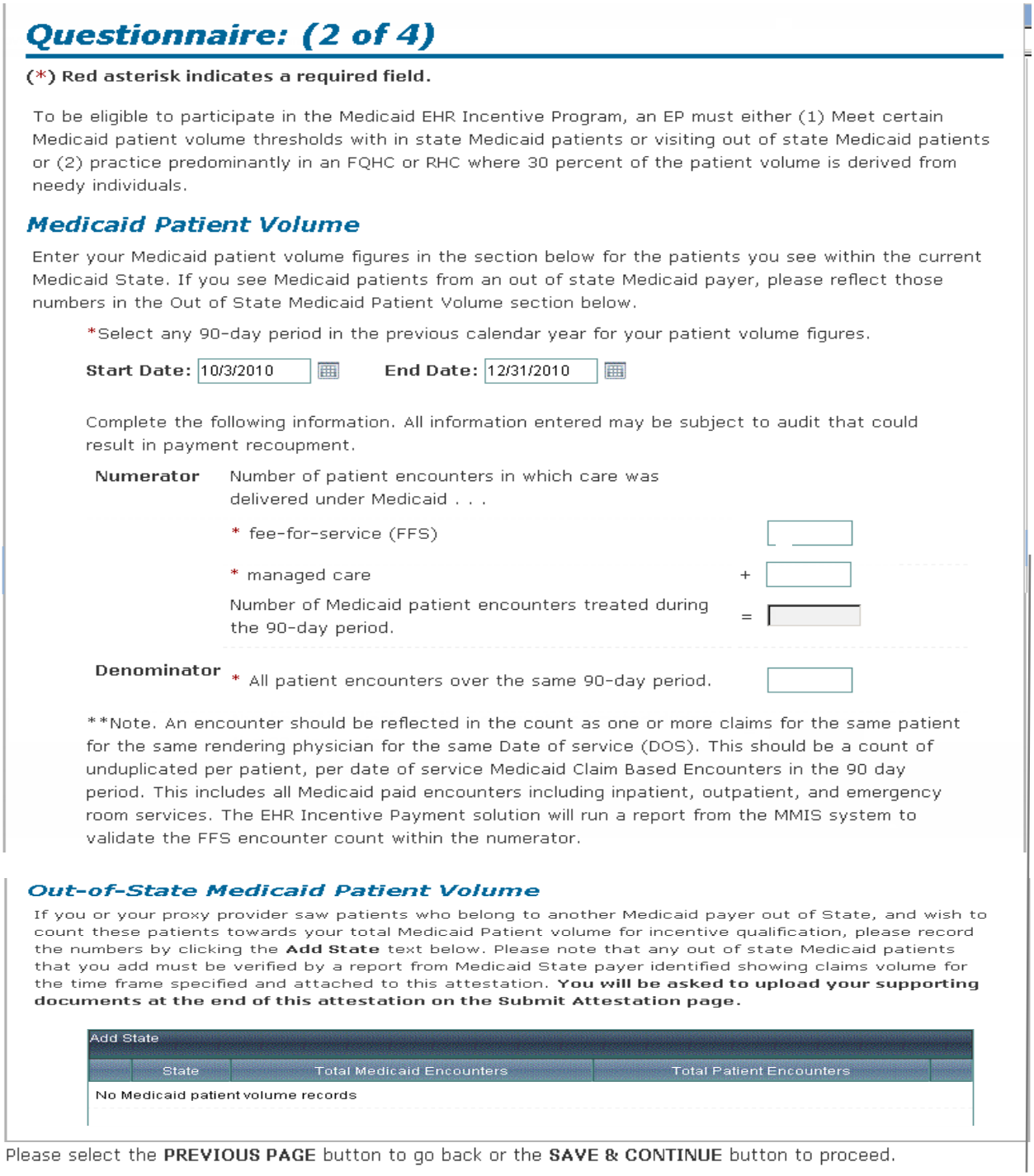
- If Pediatricians have greater than 20%, but less than a 30% eligible patient volume, their annual incentive cap is reduced to 2/3.
- Pediatricians who achieve 30% eligible patient volume are eligible to receive the full incentive amount they qualify for.

EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) and not did meet the EP 30% Medicaid patient volume threshold will be able to indicate volume and exclusions, which will be discussed with the Eligibility Screen 3 and 4.

9.3.1.3.1 Out-of-State Encounters

If the provider has significant Medicaid encounters from another state payer, then you may add to your in-state encounter count to achieve the required encounter volume. The Volume page provides functionality to add and maintain out-of-state (OOS) volume counts. When an attestation with OOS entries is submitted, the attestation will be placed in a Pend status provided the in-state volume counts are valid. WV Medicaid department will review the attestation to ensure the appropriate documentation was provided and also to review the documentation to determine if the attestation will be accepted or rejected. The provider must obtain the counts from the out of state's Medicaid MMIS and be prepared to submit the following documentation:

- Certification on official letterhead from the State Medicaid agency declaring the numbers obtained were derived from the State's MMIS and are accurate.
- Report generated by the State Medicaid agency with the total fee-for-service and Managed Care Organization encounter count and reporting period.



Questionnaire: (2 of 4)

(*) Red asterisk indicates a required field.

To be eligible to participate in the Medicaid EHR Incentive Program, an EP must either (1) Meet certain Medicaid patient volume thresholds with in state Medicaid patients or visiting out of state Medicaid patients or (2) practice predominantly in an FQHC or RHC where 30 percent of the patient volume is derived from needy individuals.

Medicaid Patient Volume

Enter your Medicaid patient volume figures in the section below for the patients you see within the current Medicaid State. If you see Medicaid patients from an out of state Medicaid payer, please reflect those numbers in the Out of State Medicaid Patient Volume section below.

*Select any 90-day period in the previous calendar year for your patient volume figures.

Start Date: 10/3/2010 **End Date:** 12/31/2010

Complete the following information. All information entered may be subject to audit that could result in payment recoupment.

Numerator Number of patient encounters in which care was delivered under Medicaid . . .

* fee-for-service (FFS)

* managed care +

Number of Medicaid patient encounters treated during the 90-day period. =

Denominator * All patient encounters over the same 90-day period.

**Note. An encounter should be reflected in the count as one or more claims for the same patient for the same rendering physician for the same Date of service (DOS). This should be a count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services. The EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count within the numerator.

Out-of-State Medicaid Patient Volume

If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the **Add State** text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. **You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.**

Add State

State	Total Medicaid Encounters	Total Patient Encounters
No Medicaid patient volume records		

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Figure 29 – Attestation Tab – Medicaid Patient Volume

1. Enter start date or end date of the EP's patient volume attestation period by typing in the date or selecting the Calendar Icon to the right of either box. The system will automatically calculate the appropriate 90 day window for the provider's chosen attestation period.
2. Enter the number of Medicaid fee-for-service and managed care patient encounters for EP or proxy entity being used by the EP for the 90 day attestation period calculated at the top of the screen. The sum of these two numbers will be the numerator for the patient volume calculation.
   - ❖ Do not add commas. System will format with commas after entry.
3. Enter the total number of patient encounters for the EP or proxy entity being used by the EP for the 90 day attestation period calculated at the top of the screen. This amount will be the Denominator for the EP's patient volume calculation.
   - ❖ Do not add commas. System will format with commas after entry.
4. Out of State Encounters (Optional)
   - ❖ The screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Each option's instructions are bulleted sections following this screen shot.

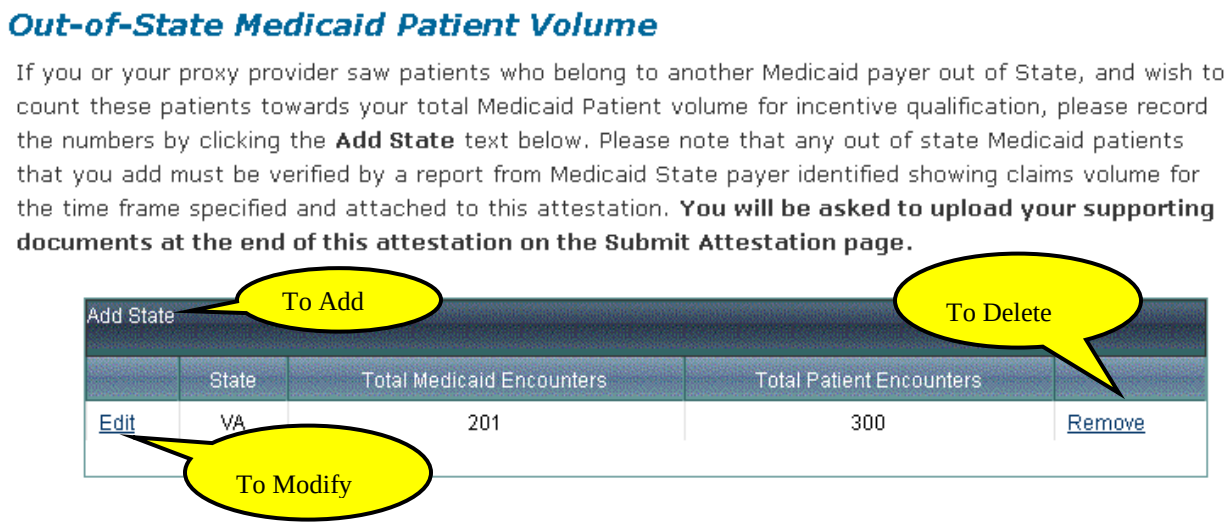


Figure 30 – Attestation Tab – Out-of-State Medicaid Patient Volume

- ❖ Select Add State to display the following screen.

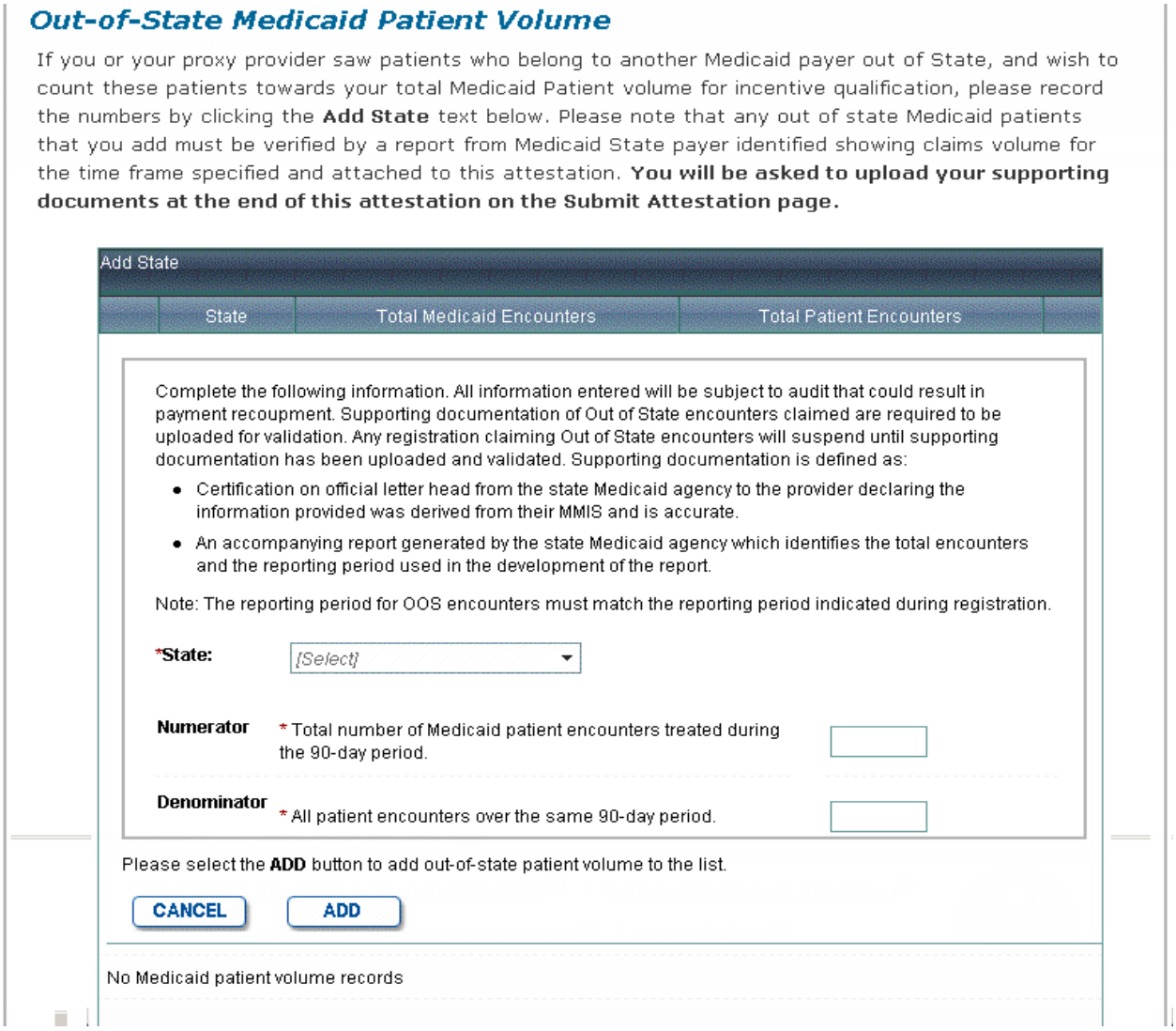


Figure 31– Out-of-State Entry – Add/Edit Screen

- To Add Out-of-State entry
    1. Select Add State to display the screen above
    2. Select a State from the drop down list
    3. Enter encounters
    4. Enter in Denominator, which is the total patient encounters for the State
    5. Select Add button
    - To enter in more States encounters, repeat Steps 1- 5

- To Modify Out-of-State entry
    - Select Edit
    - Screen display with entries, correct entries
    - Select Update button
- To Delete Out of State entry
    - Select Remove
    - Respond appropriately to the "Are you sure" question

If the eligible professional (EP) meets or exceeds the Medicaid patient volume required to receive a WV EHR Incentive Program payment, the application will display the "Payment Calculation" page. Once the EP has completed and submitted their attestation for processing, their Medicaid patient volume information will be verified against the claims and encounter data available in WVMMIS. All information entered into the application is subject to post-payment audit.

If the eligible professional does not meet the required Medicaid patient threshold after entering all of their patient volume information, additional screens will appear presenting a possible alternative patient volume calculation.

9.3.1.3.2 Volume Screen 3 – If initial Eligibility volume is not met

The purpose of this screen is to provide another opportunity to meet the eligibility volume for those providers practicing predominately in an FQHC. The following is the volume criteria if the provider practiced at an FQHC or RHC.

Eligible professionals that perform 50% of more of their overall patient encounters over a six month period in an FQHC or RHC are eligible to use an alternative, "Needy Individual" patient volume calculation to become eligible to participate in the WV EHR Incentive Program. Volume Screen 3 (shown below in Figure 36) asks the EP to provide the necessary information to determine if they are eligible to use the "Needy Individual" patient volume calculation.

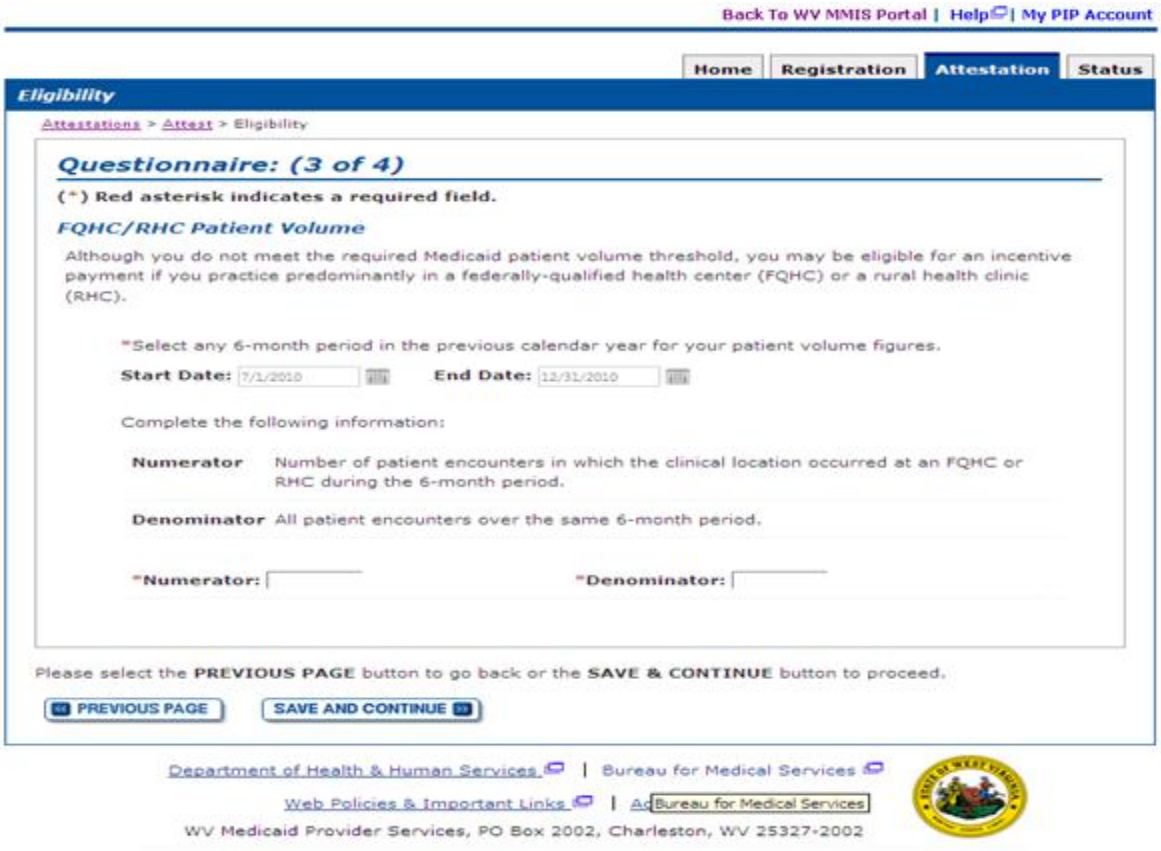


Figure 32 – Attestation Tab - FQHC/RHC Patient Volume

1. Enter the start date or end date by typing in the date or selecting the calendar icon to the right of either box. The system will automatically calculate the six month patient volume calculation period.
2. Enter the number of patient encounters performed by the EP at an FQHC or RHC in the six month period selected above. A patient encounter is defined as a unique patient, DOS, and place-of-service combination. This count must belong to the EP alone; no proxy entity measure (such as for a group practice or clinic) may be utilized when counting FQHC patient encounters. This will be the numerator used to determine if the EP practices predominantly in an FQHC.
   - ❖ Do not add commas. System will format with commas after entry.
3. Enter the total number of patient encounter performed by the EP over the six month period selected at the top of the screen. This count must belong to the EP alone; no proxy entity measure (such as a group practice or clinic) may be utilized when counting

the total number of encounters. This will be the Denominator used to determine if the EP practiced predominantly in an FQHC.

- ❖ Do not add commas. System will format with commas after entry.

4. Select Save and Continue.

The system validates if all fields have data entered.

- ❑ If any field does not contain an entry, an error message will display. Please enter the appropriate data.

If all fields contain responses, the next action depends on the data entered.

- ❑ If the EP meets the 50% patient volume threshold needed to be considered to be "practicing predominantly" in an FQHC or RHC, the EP will proceed to Volume Screen 4.
- ❑ If the EP does not meet the 50% patient volume threshold needed to be considered to be "practicing predominantly" in an FQHC or RHC, then the EP will not be allowed to continue their attestation. If the EP has questions or needs assistance, please call the WV Medicaid Provider Services Help Desk at 1-888-483-0793, option 8 for questions and assistance.

9.3.1.3.3 Volume Screen 4 – Needy Patient Volume

Providers who predominately practice in a FQHC or RHC are allowed to use criteria more inclusive "Needy Individual" patient volume measure to establish their eligibility for the EHR Incentive Program. An EP "practices predominantly" at an FQHC or an RHC when the clinical location for over 50% of his/her total patient encounters over a period of six months occur at an FQHC or RHC. Providers who practice in an FQHC or RHC but do not meet the "predominantly practicing" threshold can still qualify for an EHR Incentive Program payment using Medicaid patient volume previously discussed, but are not eligible to use the "Needy Individual" patient volume measure described in this section.

Needy Individual Encounters Defined

For purposes of calculating needy eligible patient volume, a needy patient encounters include services rendered to an individual on any one day where any of the following are met:

- ❑ Medicaid or Children's Health Insurance Program (CHIP) (or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service;

- Medicaid or CHIP (or a Medicaid or CHIP demonstration project approved under section 1115 of the Social Security Act) paid all or part of the individual's premiums, co-payments, or cost-sharing;
- The services were furnished at no cost; or
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

Eligibility Patient Volume

The solution will look to validate the number of Medicaid patient encounters reported during final attestation review. Please review the sample screen below.

Questionnaire: (4 of 4)

(*) Red asterisk indicates a required field.

Needy Patient Volume at FQHC/RHC

EPs who practice predominantly at an FQHC or RHC must meet a certain needy patient volume threshold to be eligible for an incentive payment.

*Select any 90-day period in the previous calendar year for your patient volume figures.

Start Date: 10/3/2010 **End Date:** 12/31/2010

Complete the following information:

Numerator	Number of patient encounters at an FQHC or RHC in which . . .	
	* the patient received medical assistance from Medicaid	
	* the patient received medical assistance from CHIP	+
	* patient was furnished uncompensated care	+
	* the patient was furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay	+
	Number of patient encounters at an FQHC or RHC in which the patient is a needy individual.	=
Denominator	* All patient encounters at an FQHC or RHC over the 90-day period.	

Out-of-State Needy Patient Volume at FQHC/RHC

If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the **Add State** text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. **You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.**

Add State

State	Total Needy Patient Encounters	Total FQHC/RHC Patient Encounters
No needy patient volume records		

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Figure 33 – Attestation Tab – Needy Patient Volume at FQHC/RHC

1. Enter start date or end date of the EP's patient volume attestation period by typing in the date or selecting the calendar icon to the right of either box. The application will then automatically calculate the appropriate 90-day window for the provider's chosen attestation period.

For the 90 day period, enter the number of patient encounters that meet the criteria for each question:

2. Enter the number of patients served in FQHC or RHC that received medical assistance from Medicaid.
   DEFINITION: Services rendered on any one day to an individual where Medicaid or Medicaid demonstration project under section 1115 of ARRA; demonstration project under section 1115 of the Act paid for part or all of the service or paid all or part of the premiums, co-payments, and/or cost sharing.
   - ❖ Do not add commas. The system will format with commas after entry.
3. Enter the number of patients served in FQHC or RHC that received CHIP assistance.
   DEFINITION: Services rendered on any one day to an individual where CHIP or CHIP demonstration project under section 1115 of ARRA; demonstration project under section 1115 of the Act paid for part or all of the service or paid all or part of their premiums, co-payments, and/or cost sharing.
   - ❖ Do not add commas. The system will format with commas after entry.
4. Enter the number of FQHC or RHC patient's furnished uncompensated care.
   DEFINITION: Services rendered to an individual on any one day that were uncompensated.
   - ❖ Do not add commas. The system will format with commas after entry.
5. Enter the number of FQHC or RHC patients encounters provided services at either no cost or reduced cost based on the sliding scale determined by the individual's ability to pay. DEFINITION: Services rendered to an individual on any one day on a sliding scale.
   - ❖ Do not add commas. The system will format with commas after entry.

6. The system calculates the number of encounters for "Needy Individuals" encounters using the information entered in steps 1-5.
7. Enter the Denominator.
   DEFINITION: This is the total number of patient encounters the FQHC/RHC had for the specified time frame based on reports from the practice management system or EHR systems.
   - ❖ Do not add commas. The system will format with commas after entry.
8. Out of State Entry (Optional).

   The screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Each option's instructions are bulleted sections following this screen shot.

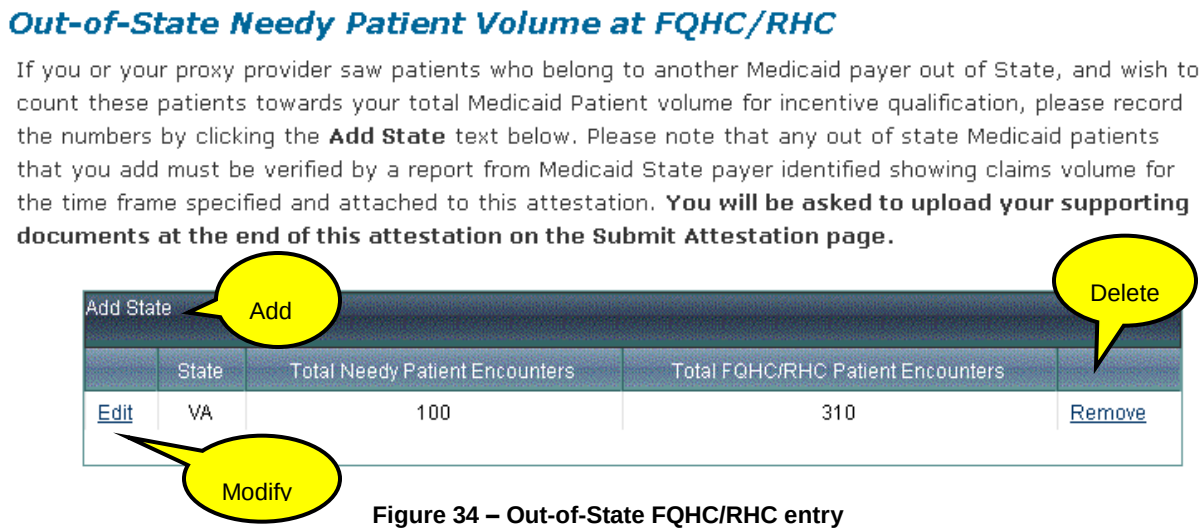


Figure 34 – Out-of-State FQHC/RHC entry

❖ To Add

- Select Add State to display the following screen.

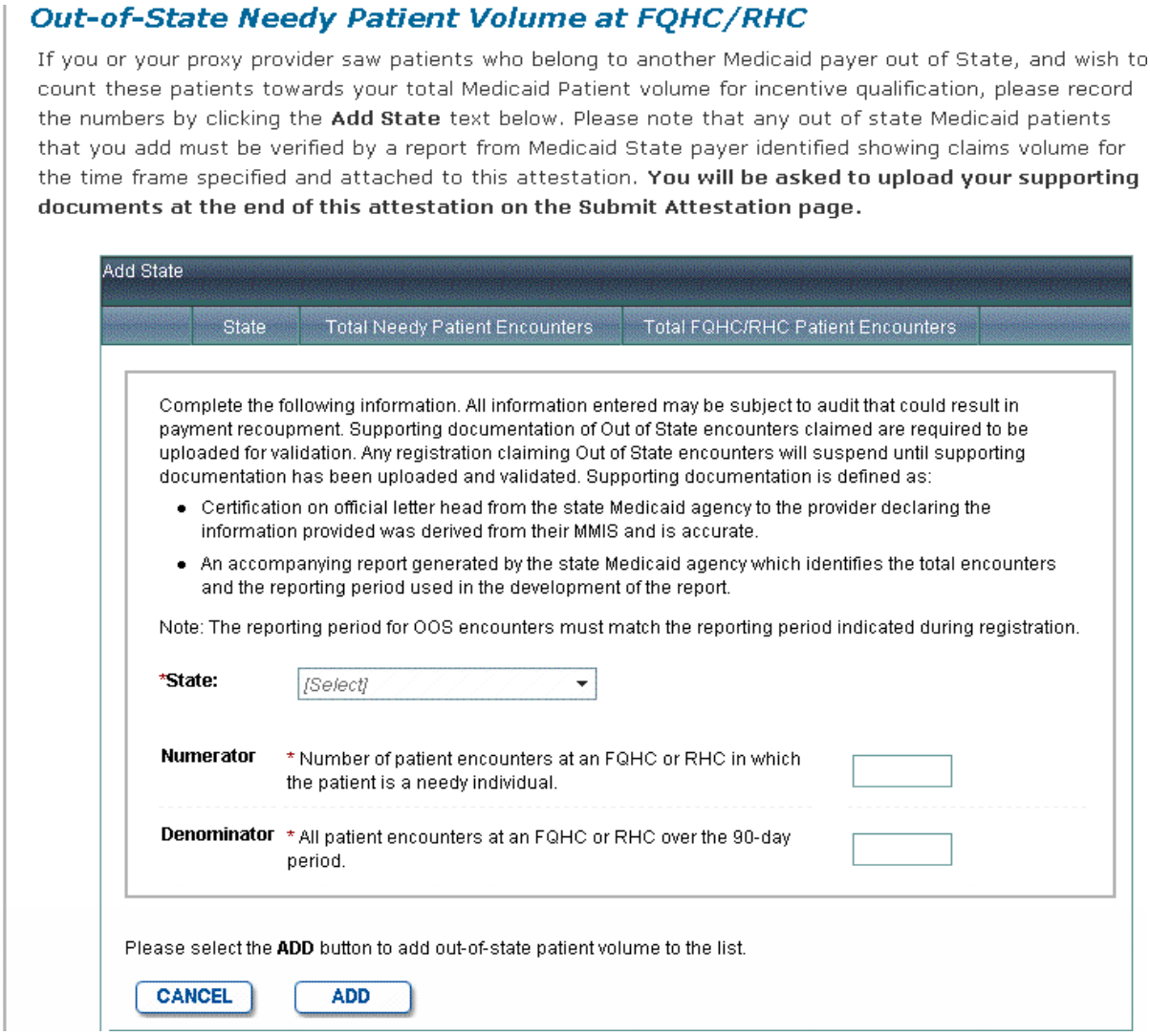


Figure 35 – Out-of-state Needy Patient Volume Entry/Edit Screen

- Enter in each value (Definitions of each field may be found in the Needy Patient volume section above).
- Select Add

❖ To Edit

1. Select Edit next to the state
2. The Out-of-State Patient Volume Entry screen displays with your entries
3. Modify the entries
4. Select Update

❖ To Delete

1. Select Delete on the desired state
2. Respond appropriately to the "Are you sure?" question

9. Select Save and Continue to save all changes.
10. The system validates if all fields have data entered.

An error message displays if the user did not supply dates, numerator and a Denominator. Please enter the appropriate data.

If all fields have been answered AND the entries meet the volume percentages, the Incentive Payment schedule screen displays.

If the provider does not meet the volume percentages listed above, the provider is ineligible and will not be allowed to continue. Attestation status will state Attestation Not Allowed. Contact WV Medicaid Provider Services Help Desk at 1-888-483-0793, option 8 for questions and assistance.

9.3.2 Attestation Payment

The payment schedule is a proposed schedule based on the answers provided in the Eligibility section. The WV EHR Incentive Program application will execute behind-the-scenes to validate questions that asked for claims volume. If the volume was not found, the application will set the eligibility status to Ineligible and the Attestation status to Attestation Not Allowed.

Pediatrician EHR Incentive Payments
(Between 20 – 29 Percent)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$14,167					
CY 2012	$5,667	$14,167				
CY 2013	$5,667	$5,667	$14,167			
CY 2014	$5,667	$5,667	$5,667	$14,167		
CY 2015	$5,667	$5,667	$5,667	$5,667	$14,167	
CY 2016	$5,665	$5,667	$5,667	$5,667	$5,667	$14,167
CY 2017		$5,665	$5,667	$5,667	$5,667	$5,667
CY 2018			$5,665	$5,667	$5,667	$5,667
CY 2019				$5,665	$5,667	$5,667
CY 2020					$5,665	$5,667
CY 2021						$5,665
TOTAL	$42,500	$42,500	$42,500	$42,500	$42,500	$42,500

Figure 36 – Pediatrician 20% volume payment calendar

Calendar of Payments for Providers						
Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Figure 37 – Eligible Providers Payment calendar

9.3.3 Certified EHR Technology

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) is the body that tests and certifies EHR systems. If the EHR system is approved, it is assigned a certification number. The web site below is the Certified Health IT Product List website to look up EHR certification number or even to register an EHR. Please contact the Help Contacts listed on the Certified Health IT Product List web site if you have questions.

http://onc-chpl.force.com/ehrcert

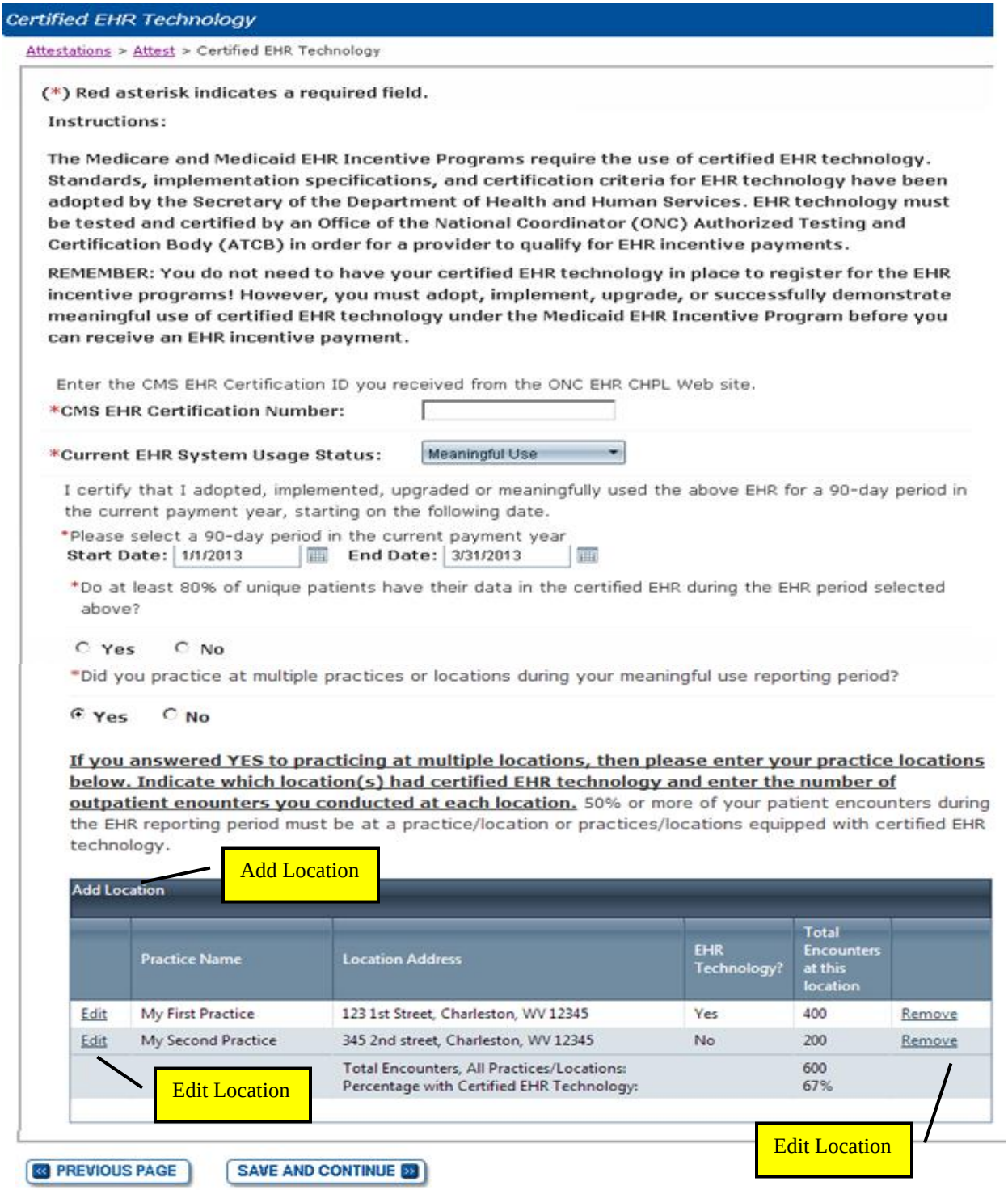


Figure 38 – Attestation Tab – Certified EHR Technology Page

1. Enter the EHR Certification number.
2. Select the option of Meaningful Use.
3. The EHR period that displays is based on your payment as outlined below:
    - ❖ 90 day selection, date range controls display for the following conditions.
        1. AIU, which is the first year payment
        2. 1st year of Meaningful Use, second year of payment
        3. 2014 regardless of payment year
    - ❖ Otherwise, one year date range is required according to your payment schedule.
4. Respond to the 80% of patients records are in an EHR question.
    - ❖ If answered No, attestation progress is not allowed
5. Respond to the Multiple Locations/Practices question.
    - ❖ If you did not practice at multiple locations/practices during the Meaningful Use period, select **No**. You have addressed the multiple locations/practices question.
    - ❖ If you did practice at multiple locations/practices during the Meaningful Use period, select **Yes**. You will need to add the location/practice information and the total number of encounters for each location. The Location/Practice table allows you to edit or delete the locations/practices if needed. Per CMS, at least 50% of the encounters must be at locations/practices with a certified EHR.
    - ❖ **Add Location** Instructions
        1. Select the **Add Location** icon on the upper left hand corner of the table.
        2. Enter the Practice Name.
        3. Enter the Practice location.
        4. Enter the number of encounters.
        5. Repeat for each location.

        The system will calculate the percentage.

- **Edit** Location Instructions:

  1.Select the **Edit** hyperlink.

  2.The row is open for your edits.

  - The system will calculate the percentage.

- **Delete** Location Instructions:

  1.Select the **Delete** hyperlink.

  2.The row is deleted.

  - The system will calculate the percentage.

6. Select Save and Continue.
7. The system validates if all fields have data entered.

   Error message displays if the user did not:

   - supply EHR Certification number
   - supply a start and end date
   - enter the appropriate data
   - If practiced at multiple locations and the percentage does not meet 50% of encounters at locations

If no errors occur, the Attestation Topic page displays. If all topics have been answered, the Submit button will be available.

9.4 Meaningful Use Core Measures

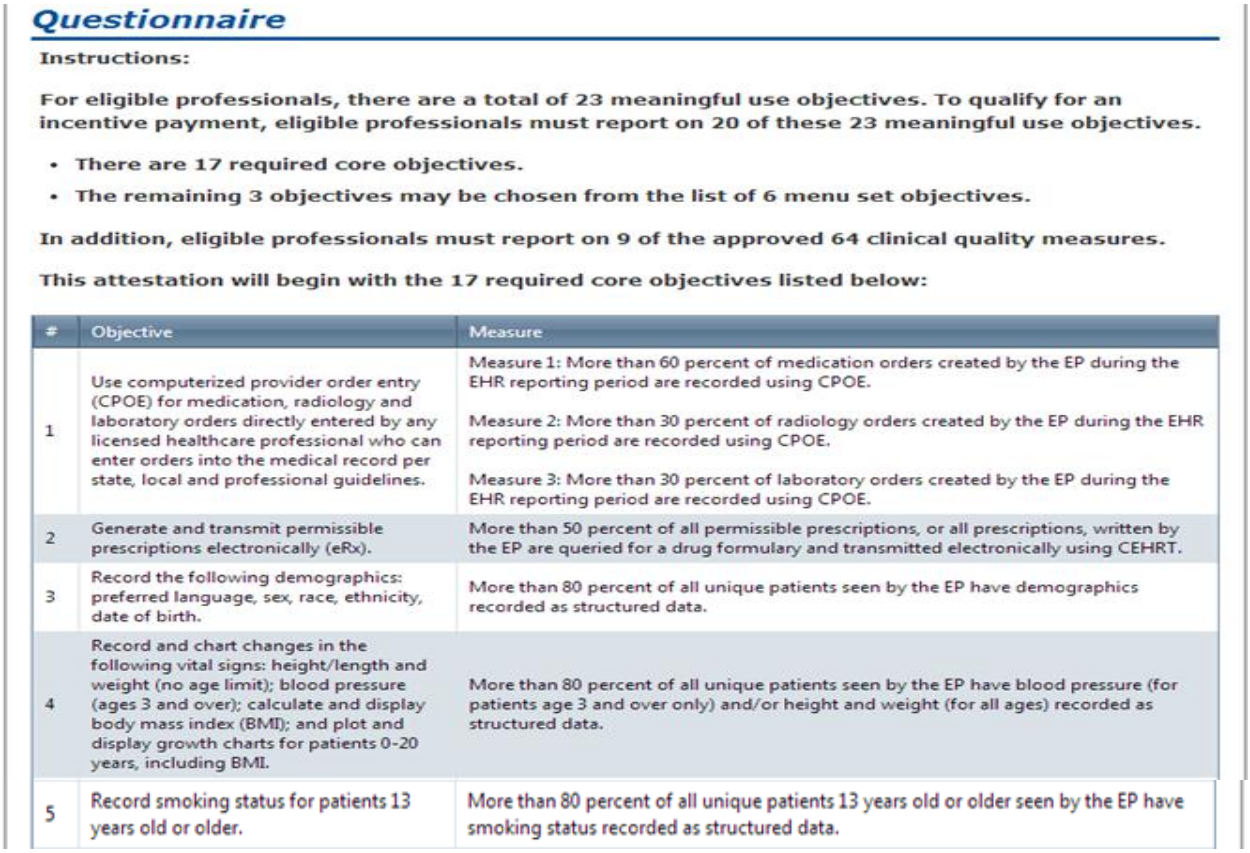
This section addresses the navigation of the Meaningful Use screens. Screen shots are displayed within the Meaningful Use Core Screenshots section.

CMS requires that providers attest to 17 defined "core" Meaningful Use criteria. The screen below lists the 17 questions currently required for Meaningful Use Stage 2 reporting for eligible providers.

Providers, please note that each MU question is required. The application will validate that all questions are completed during attestation, but does not validate that the questions meet the percentile required for Meaningful Use of an EHR system until after the questionnaire is

submitted. At this point, the system will reject the provider if provider does not meet the requirement percentiles for appropriate EHR usage.

This manual addresses the navigation of the Meaningful Use screens. Screen shots are displayed within the Meaningful Use Core Screenshots section.



Questionnaire

Instructions:

For eligible professionals, there are a total of 23 meaningful use objectives. To qualify for an incentive payment, eligible professionals must report on 20 of these 23 meaningful use objectives.

- **There are 17 required core objectives.**
- **The remaining 3 objectives may be chosen from the list of 6 menu set objectives.**

In addition, eligible professionals must report on 9 of the approved 64 clinical quality measures.

This attestation will begin with the 17 required core objectives listed below:

#	Objective	Measure
1	Use computerized provider order entry (CPOE) for medication, radiology and laboratory orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines.	Measure 1: More than 60 percent of medication orders created by the EP during the EHR reporting period are recorded using CPOE. Measure 2: More than 30 percent of radiology orders created by the EP during the EHR reporting period are recorded using CPOE. Measure 3: More than 30 percent of laboratory orders created by the EP during the EHR reporting period are recorded using CPOE.
2	Generate and transmit permissible prescriptions electronically (eRx).	More than 50 percent of all permissible prescriptions, or all prescriptions, written by the EP are queried for a drug formulary and transmitted electronically using CEHRT.
3	Record the following demographics: preferred language, sex, race, ethnicity, date of birth.	More than 80 percent of all unique patients seen by the EP have demographics recorded as structured data.
4	Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.	More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.
5	Record smoking status for patients 13 years old or older.	More than 80 percent of all unique patients 13 years old or older seen by the EP have smoking status recorded as structured data.

6	Use clinical decision support to improve performance on high-priority health conditions.	Measure 1: Implement five clinical decision support interventions related to four or more clinical quality measures at a relevant point in patient care for the entire EHR reporting period. Absent four clinical quality measures related to an EP's scope of practice or patient population, the clinical decision support interventions must be related to high-priority health conditions. Measure 2: The EP has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.
7	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.	Measure 1: More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information. Measure 2: More than 5 percent of all unique patients seen by the EP during the EHR reporting period (or their authorized representatives) view, download, or transmit to a third party their health information.
8	Provide clinical summaries for patients for each office visit.	Clinical summaries provided to patients or patient-authorized representatives within one business day for more than 50 percent of office visits.
9	Protect electronic health information created or maintained by the certified EHR technology (CEHRT) through the implementation of appropriate technical capabilities.	Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a) (1), including addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the provider's risk management process for EPs.
10	Incorporate clinical lab-test results into Certified EHR Technology (CEHRT) as structured data.	More than 55 percent of all clinical lab tests results ordered by the EP during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in Certified EHR Technology as structured data.
11	Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research, or outreach.	Generate at least one report listing patients of the EP with a specific condition.
12	Use clinically relevant information to identify patients who should receive reminders for preventive/follow-up care and send these patients the reminders, per patient preference.	More than 10 percent of all unique patients who have had 2 or more office visits with the EP within the 24 months before the beginning of the EHR reporting period were sent a reminder, per patient preference when available.
13	Use clinically relevant information from Certified EHR Technology to identify patient-specific education resources and provide those resources to the patient.	Patient-specific education resources identified by Certified EHR Technology are provided to patients for more than 10 percent of all unique patients with office visits seen by the EP during the EHR reporting period.
14	The EP who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation.	The EP who performs medication reconciliation for more than 50 percent of transitions of care in which the patient is transitioned into the care of the EP.
15	The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.	Measure 1: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50 percent of transitions of care and referrals. Measure 2: The EP who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 10 percent of such transitions and referrals either (a) electronically transmitted using CEHRT to a recipient or (b) where the recipient receives the summary of care record via exchange facilitated by an organization that is a NwHIN Exchange participant or in a manner that is consistent with the governance mechanism ONC establishes for the NwHIN. Measure 3: An EP must satisfy one of the following criteria: • Conducts one or more successful electronic exchanges of a summary of care document, a part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B)) with a recipient who has EHR technology that was developed or designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2). • Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.
16	Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.
17	Use secure electronic messaging to communicate with patients on relevant health information.	A secure message was sent using the electronic messaging function of CEHRT by more than 5 percent of unique patients (or their authorized representatives) seen by the EP during the EHR reporting period.

Figure 39 – Meaningful Use Core Measures Question List

9.4.1 Meaningful Use Core Question General Workflow Functionality

Link to CMS definition

- Each screen has a link to the CMS definition and detail of each question for the provider to access to review the specific requirements for completing the numerator/Denominator for each question and if elected, what the exception criteria must be for an organization to claim and exemption for that question.

Save and Continue Button

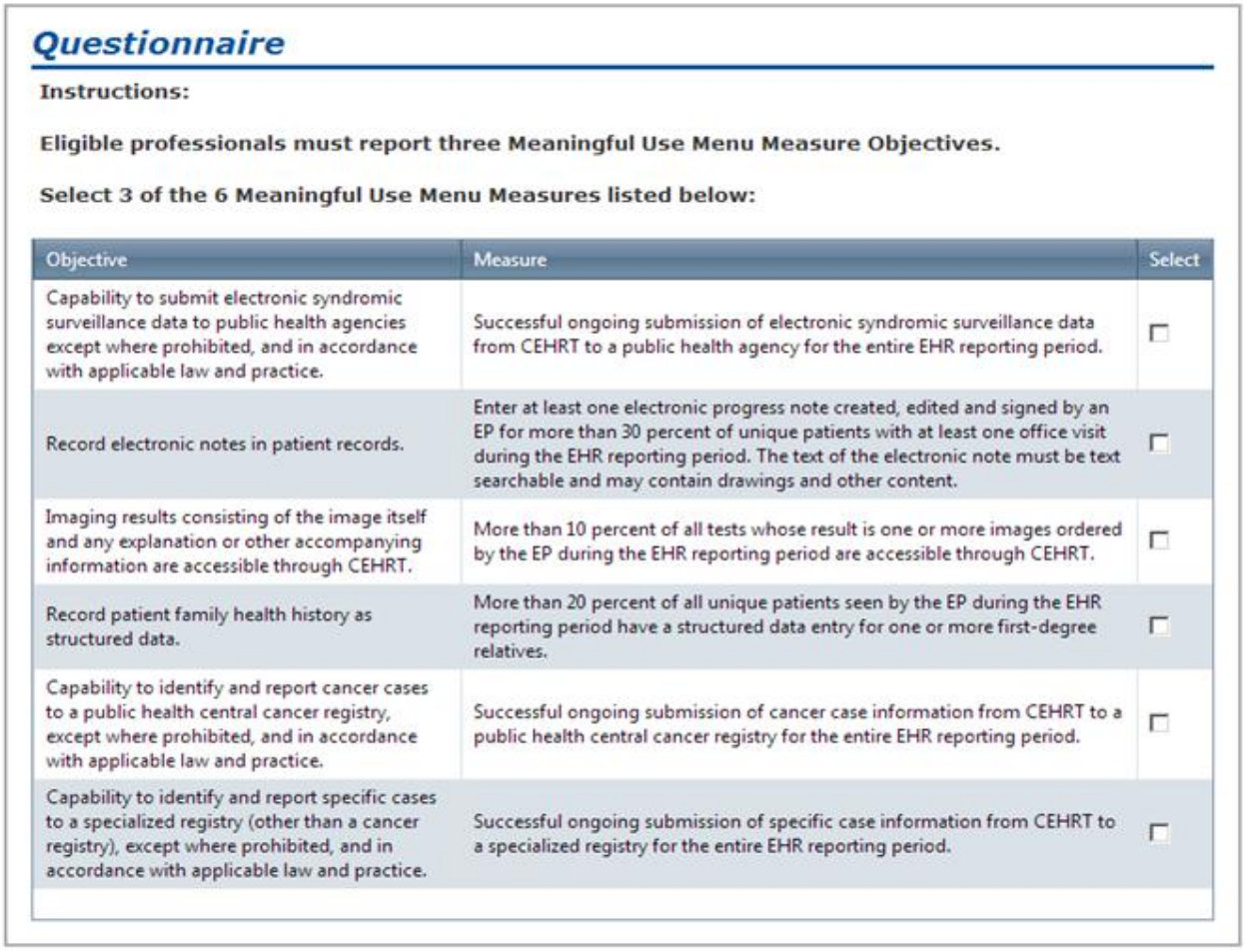
- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not filled, the page will continue to display until required fields are corrected.
  - If required fields are filled, the next screen displays.

Previous Button

- Displays the previous screen.

9.5 Meaningful Use Menu Measures

CMS has defined a total of six Meaningful Use Menu Measures. CMS is requiring the provider to select three questions. Meaningful Use Menu Measures Screenshots section displays each question. The following screen shots list the Meaningful Use Menu Measures questions.



Questionnaire

Instructions:

Eligible professionals must report three Meaningful Use Menu Measure Objectives.

Select 3 of the 6 Meaningful Use Menu Measures listed below:

Objective	Measure	Select
Capability to submit electronic syndromic surveillance data to public health agencies except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of electronic syndromic surveillance data from CEHRT to a public health agency for the entire EHR reporting period.	☐
Record electronic notes in patient records.	Enter at least one electronic progress note created, edited and signed by an EP for more than 30 percent of unique patients with at least one office visit during the EHR reporting period. The text of the electronic note must be text searchable and may contain drawings and other content.	☐
Imaging results consisting of the image itself and any explanation or other accompanying information are accessible through CEHRT.	More than 10 percent of all tests whose result is one or more images ordered by the EP during the EHR reporting period are accessible through CEHRT.	☐
Record patient family health history as structured data.	More than 20 percent of all unique patients seen by the EP during the EHR reporting period have a structured data entry for one or more first-degree relatives.	☐
Capability to identify and report cancer cases to a public health central cancer registry, except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of cancer case information from CEHRT to a public health central cancer registry for the entire EHR reporting period.	☐
Capability to identify and report specific cases to a specialized registry (other than a cancer registry), except where prohibited, and in accordance with applicable law and practice.	Successful ongoing submission of specific case information from CEHRT to a specialized registry for the entire EHR reporting period.	☐

Figure 40 – Meaningful Use Menu Measure Question List

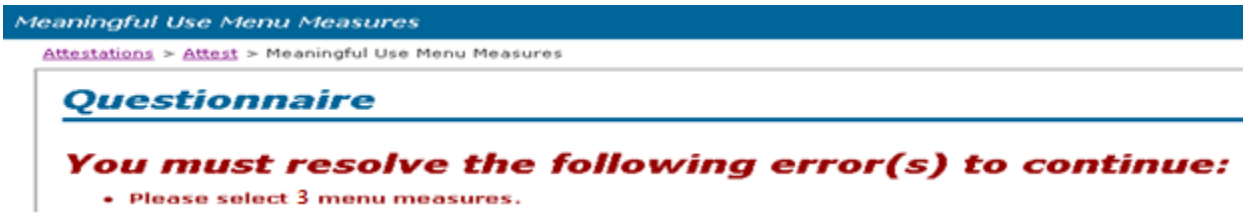
- A checkmark indicates that you have selected that question. The application will allow you to select more than 3 questions.

Potential Error Messages on this Screen

The following are the error messages if the minimum requirements are not meant:

MESSAGE 2 - User receives the following error and cannot continue attestation process until error is fixed.

- Selects less than three items, the following error message displays.



Application Question Display for Menu Measures

The application will only display the questions that were selected. The navigation is the same as was outlined in the Meaningful Use Core section, as show again below.

The application will not validate if the required score has been met at the time of entry, it will only tell the user if the appropriate questions have been completed or not. **The validation of EHR usage percentiles is done after the attestation is submitted.**

9.5.1 Meaningful Use Menu Measures Question General Workflow Functionality

Link to CMS definition

- Each MU question screen has a link to the CMS definition and detail of each question for the provider to access to review the specific requirements for completing the numerator/Denominator for each question and if elected, what the exception criteria must be for an organization to claim and exemption for that question.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not filled, the page will continue to display until required fields are corrected.
  - If required fields are filled, the next screen displays.

Previous Button

- Displays the previous screen.

9.6 Clinical Quality Measures

CMS requires that the provider select nine of the 64 CQMs.

> *"CMS has also published a recommended core set of CQMs for eligible professionals that focus on high-priority health conditions and best-practices for care delivery.*
> *Nine CQMs for **adult populations** that meet all of the program requirements*

*Nine CQMs for **pediatric populations** that meet all of the program requirements.*

Questionnaire

Instructions:

EPs must report on 9 of the 64 approved Clinical Quality Measures. The selected CQMs must cover at least 3 of the National Quality Strategy domains.

You must submit 9 Clinical Quality Measures from the list below:
(You have selected 0 CQMs)

* Recommended core CQM for adult population
** Recommended core CQM for pediatric population

Identifier(s)	Clinical Quality Measure Title & Description	Domain	Select
CMS146v2 ** NQF 0002	**Title:** Appropriate Testing for Children with Pharyngitis **Description:** Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Efficient Use of Healthcare Resources	☐
CMS137v2 NQF 0004	**Title:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment **Description:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Clinical Process/Effectiveness	☐
CMS165v2 * NQF 0018	**Title:** Controlling High Blood Pressure **Description:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Clinical Process/Effectiveness	☐
CMS156v2 * NQF 0022	**Title:** Use of High-Risk Medications in the Elderly **Description:** Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Patient Safety	☐

CMS155v2 ** NQF 0024	**Title:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents **Description:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/ Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation • Percentage of patients with counseling for nutrition Percentage of patients with counseling for physical activity	Population/Public Health	☐
CMS138v2 * NQF 0028	**Title:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention **Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Population/Public Health	☐
CMS125v2 NQF 0031	**Title:** Breast Cancer Screening **Description:** Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	Clinical Process/Effectiveness	☐
CMS124v2 NQF 0032	**Title:** Cervical Cancer Screening **Description:** Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	Clinical Process/Effectiveness	☐
CMS153v2 ** NQF 0033	**Title:** Chlamydia Screening for Women **Description:** Percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Population/Public Health	☐
CMS130v2 NQF 0034	**Title:** Colorectal Cancer Screening **Description:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Clinical Process/Effectiveness	☐
CMS126v2 ** NQF 0036	**Title:** Use of Appropriate Medications for Asthma **Description:** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Clinical Process/Effectiveness	☐
CMS117v2 ** NQF 0038	**Title:** Childhood Immunization Status **Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Population/Public Health	☐
CMS147v2 NQF 0041	**Title:** Preventive Care and Screening: Influenza Immunization **Description:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Population/Public Health	☐
CMS127v2 NQF 0043	**Title:** Pneumonia Vaccination Status for Older Adults **Description:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Clinical Process/Effectiveness	☐
CMS166v3 * NQF 0052	**Title:** Use of Imaging Studies for Low Back Pain **Description:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Efficient Use of Healthcare Resources	☐

CMS131v2 NQF 0055	**Title:** Diabetes: Eye Exam **Description:** Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	Clinical Process/Effectiveness	☐
CMS123v2 NQF 0056	**Title:** Diabetes: Foot Exam **Description:** Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.	Clinical Process/Effectiveness	☐
CMS122v2 NQF 0059	**Title:** Diabetes: Hemoglobin A1c Poor Control **Description:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Clinical Process/Effectiveness	☐
CMS148v2 NQF 0060	**Title:** Hemoglobin A1c Test for Pediatric Patients **Description:** Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.	Clinical Process/Effectiveness	☐
CMS134v2 NQF 0062	**Title:** Diabetes: Urine Protein Screening **Description:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Clinical Process/Effectiveness	☐
CMS163v2 NQF 0064	**Title:** Diabetes: Low Density Lipoprotein (LDL) Management **Description:** Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.	Clinical Process/Effectiveness	☐
CMS164v2 NQF 0068	**Title:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic **Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	Clinical Process/Effectiveness	☐
CMS154v2 ** NQF 0069	**Title:** Appropriate Treatment for Children with Upper Respiratory Infection (URI) **Description:** Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	Efficient Use of Healthcare Resources	☐
CMS145v2 NQF 0070	**Title:** Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) **Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.	Clinical Process/Effectiveness	☐
CMS182v3 NQF 0075	**Title:** Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control **Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).	Clinical Process/Effectiveness	☐

CMS135v2 NQF 0081	**Title:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Clinical Process/Effectiveness	☐
CMS144v2 NQF 0083	**Title:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Clinical Process/Effectiveness	☐
CMS143v2 NQF 0086	**Title:** Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation **Description:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.	Clinical Process/Effectiveness	☐
CMS167v2 NQF 0088	**Title:** Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy **Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	Clinical Process/Effectiveness	☐
CMS142v2 NQF 0089	**Title:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care **Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	Clinical Process/Effectiveness	☐
CMS139v2 NQF 0101	**Title:** Falls: Screening for Future Fall Risk **Description:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patient Safety	☐
CMS161v2 NQF 0104	**Title:** Adult Major Depressive Disorder (MDD): Suicide Risk Assessment **Description:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Clinical Process/Effectiveness	☐
CMS128v2 NQF 0105	**Title:** Anti-depressant Medication Management **Description:** Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	Clinical Process/Effectiveness	☐

CMS136v3 ** NQF 0108	**Title:** ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Description:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/ hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Clinical Process/Effectiveness	☐
CMS169v2 NQF 0110	**Title:** Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use **Description:** Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Clinical Process/Effectiveness	☐
CMS157v2 NQF 0384	**Title:** Oncology: Medical and Radiation – Pain Intensity Quantified **Description:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Patient and Family Engagement	☐
CMS141v3 NQF 0385	**Title:** Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients **Description:** Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	Clinical Process/Effectiveness	☐
CMS140v2 NQF 0387	**Title:** Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer **Description:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	Clinical Process/Effectiveness	☐
CMS129v3 NQF 0389	**Title:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients **Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Efficient Use of Healthcare Resources	☐
CMS62v2 NQF 0403	**Title:** HIV/AIDS: Medical Visit **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.	Clinical Process/Effectiveness	☐
CMS52v2 NQF 0405	**Title:** HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis **Description:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	Clinical Process/Effectiveness	☐
CMS77v2	**Title:** HIV/AIDS: RNA Control for Patients with HIV **Description:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	Clinical Process/Effectiveness	☐

CMS2v3 *,** NQF 0418	**Title:** Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan **Description:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	Population/Public Health	☐
CMS68v3 * NQF 0419	**Title:** Documentation of Current Medications in the Medical Record **Description:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Patient Safety	☐
CMS69v2 * NQF 0421	**Title:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up **Description:** Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter Normal Parameters: Age 65 years and older BMI >= 23 and < 30 Age 18-64 years BMI >= 18.5 and < 25	Population/Public Health	☐
CMS132v2 NQF 0564	**Title:** Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures **Description:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	Patient Safety	☐
CMS133v2 NQF 0565	**Title:** Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery **Description:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	Clinical Process/Effectiveness	☐
CMS158v2 NQF 0608	**Title:** Pregnant Women That Had HBsAg Testing **Description:** This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	Clinical Process/Effectiveness	☐
CMS159v2 NQF 0710	**Title:** Depression Remission at Twelve Months **Description:** Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Clinical Process/Effectiveness	☐
CMS160v2 NQF 0712	**Title:** Depression Utilization of the PHQ-9 Tool **Description:** Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.	Clinical Process/Effectiveness	☐
CMS75v2 **	**Title:** Children Who Have Dental Decay or Cavities **Description:** Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.	Clinical Process/Effectiveness	☐

CMS177v2 NQF 1365	**Title:** Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment **Description:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Patient Safety	☐
CMS82v1 NQF 1401	**Title:** Maternal Depression Screening **Description:** The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	Population/Public Health	☐
CMS74v3	**Title:** Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists **Description:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Clinical Process/Effectiveness	☐
CMS61v3	**Title:** Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed **Description:** Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	Clinical Process/Effectiveness	☐
CMS64v3	**Title:** Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) **Description:** Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	Clinical Process/Effectiveness	☐
CMS149v2	**Title:** Dementia: Cognitive Assessment **Description:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.	Clinical Process/Effectiveness	☐
CMS65v3	**Title:** Hypertension: Improvement in Blood Pressure **Description:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Clinical Process/Effectiveness	☐
CMS50v2 *	**Title:** Closing the Referral Loop: Receipt of Specialist Report **Description:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Care Coordination	☐
CMS66v2	**Title:** Functional Status Assessment for Knee Replacement **Description:** Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patient and Family Engagement	☐
CMS56v2	**Title:** Functional Status Assessment for Hip Replacement **Description:** Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patient and Family Engagement	☐
CMS90v3 *	**Title:** Functional Status Assessment for Complex Chronic Conditions **Description:** Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.	Patient and Family Engagement	☐
CMS179v2	**Title:** ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range **Description:** Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Patient Safety	☐
CMS22v2	**Title:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented **Description:** Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.	Population/Public Health	☐

Figure 41 - Clinical Quality Measures List

Potential Error Messages on this Screen

The following are the error messages if the minimum requirements are not met:

MESSAGE 2 – User select 7 CQMs

- ✓ The error message displays the number of questions that need to be selected to meet the minimum requirement.

Application Question Display for Clinical Quality Measures

Link to CMS definition

- ♦ Each screen has a link to the CMS definition and detail of each question for the provider to access to review the specific requirements for completing the numerator/Denominator for each question and if elected, what the exception criteria must be for an organization to claim and exemption for that question.

Save and Continue Button

- ♦ When selected, a check is executed to determine if all required fields have information entered.
  - o If required fields are not filled, the page will continue to display until required fields are corrected.
  - o If required fields are filled, the next screen displays.

Previous Button

- ♦ Displays the previous screen

9.7 Submit Attestation and payment status

The Submit Attestation button remains disabled if the eligibility checks failed or not all required questions have been answered. If the eligibility checks passed and all required questions are answered, then the Submit Attestation button is available. On selection of the Submit Attestation button, the following screen displays.

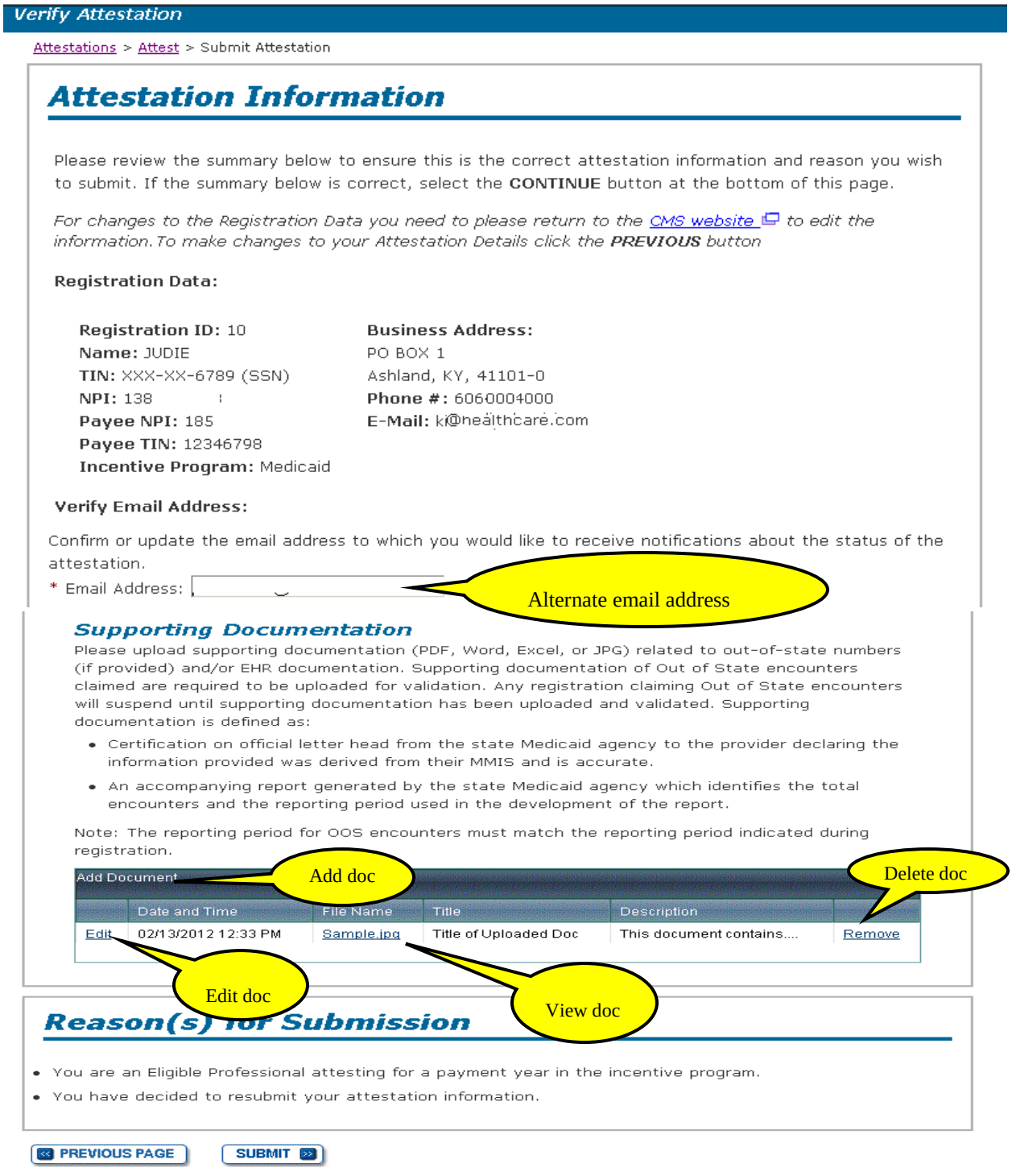


Figure 42 – Attestation Tab – Submit Attestation Check Email Address

Enter an email address if the one listed in the Email field is incorrect.

9.8 Supporting Documentation

Documents may be in the form of PDF, Jpeg, Excel, or Word files four megabytes or smaller. Section 3 of this document lists required documentation. If you have entered OOS encounters, you are required to upload two documents, which are a certification letter that volumes are from the state's MMIS and the report from the state's MMIS department.

- To Add Document:

1. Select Add Document to display the following screen.

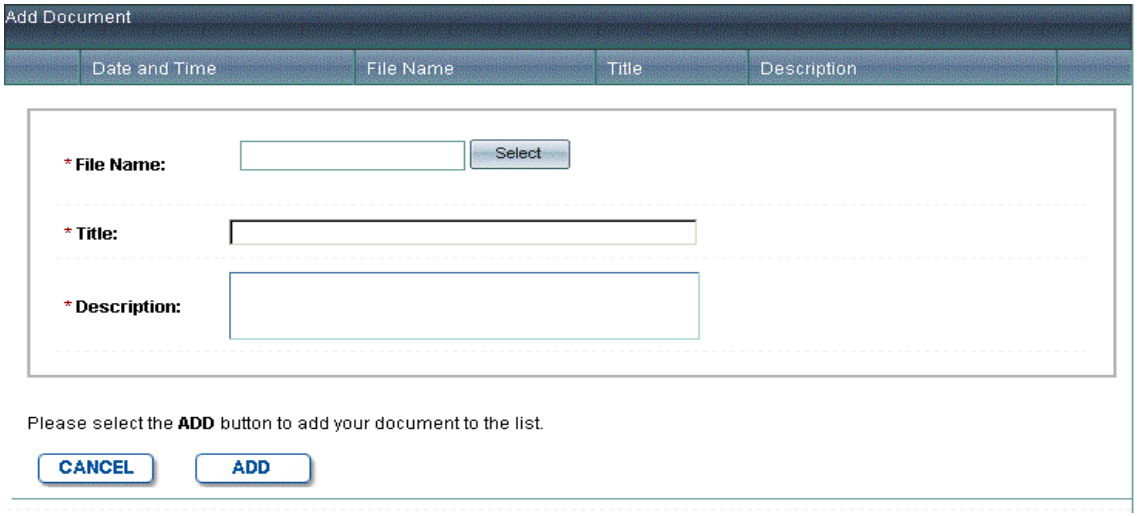


Figure 43 - Supporting Documentation – Add Screen

- Select File to upload from your computer.
- Select the Select button.
- On Files window, navigate through your computer and select the file to upload.
- Select Ok.
- Document name displays in the File Name box.

2. Enter in Title.
3. Enter in Description of file.

4. Select Add.

❖ To add more files, Repeat Steps.

❖ To Edit Document :

1. Select Edit next to the desired document.
2. The Supporting Documentation – Add screen fields displays with Update and Cancel buttons instead.
3. Modify the information.
4. Select Update.

To Delete Document:

1. Select Delete next to the desired document.
2. Answer "Are you sure?" question appropriately.

Select the Submit button. This displays the Successful Submission screen. An example is below:

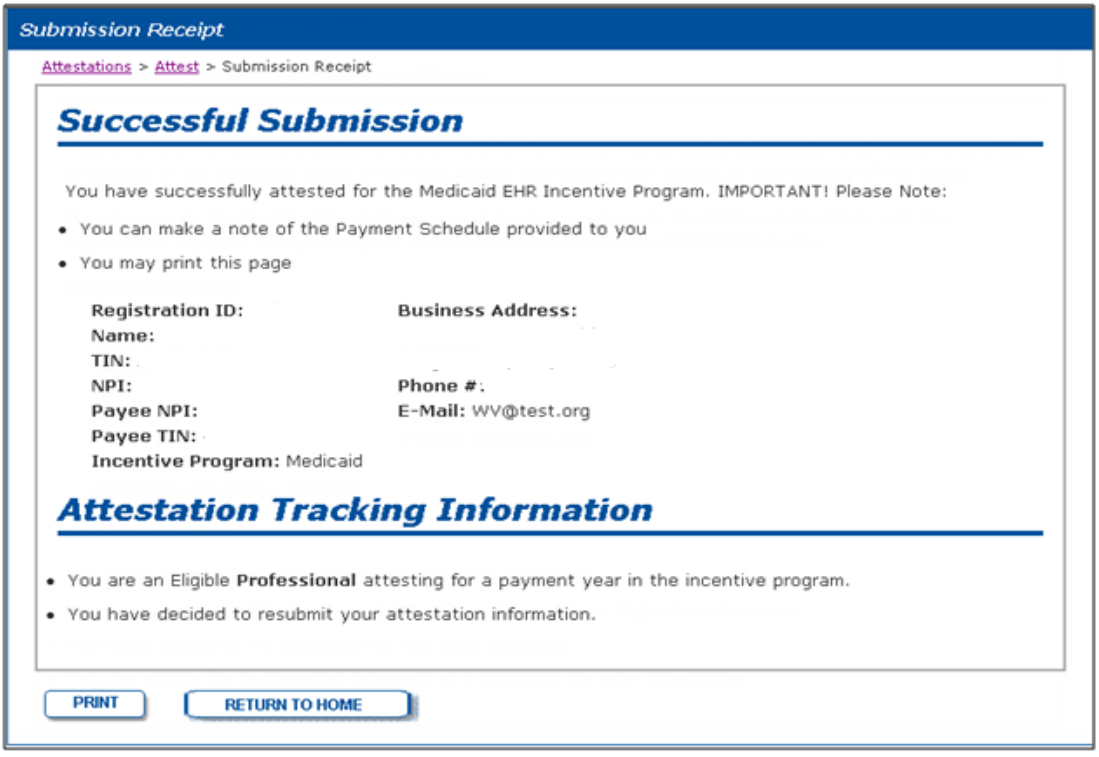


Figure 44 – Attestation Tab - Submission Receipt Window

Upon the successful submission, the attestation entry process is completed. The WV EHR Incentive Program provides 48 hours to make changes. If changes are made, the 48 hour count restarts. Once the 48 hours have expired, the WV EHR Incentive Program will execute final eligibility checks. These include validating that the Medicaid patient encounter amounts entered by the EP are within a reasonable range of the fee-for-service claim and managed care encounter volume stored in the WVMMIS and querying the CMS NLR to determine if the attesting EP has already received an EHR Incentive Program payment from Medicare or another state's Medicaid EHR Incentive Program. This processing will take time and the payment will not be sent immediately after submitting the attestation.

After the eligibility checks and payment checks are executed, the WV EHR Incentive Program will send an email with the status that was found. If an eligibility or payment error has occurred and assistance is needed, please contact the WV Medicaid Provider Services Help Desk at 1-888-483-0793, option 8.

The WV EHR Incentive Program application will display the errors. Select the Status tab to display the current Attestation status.

10. Status Grid

The table lists the attestation status that may occur.

Provider Screen Status	Admin Portal Attestation Status	Description - Provider
Attestation Not Allowed	Attestation Not Allowed	Provider's registration did not pass the inital eligibility check.
Attestation Not Started	Attestation Not Started	Provider's registration has processed successful; but the provider has not yet logged into the PIP solution and begun their attestation
Attestation In Progress	Attestation In Progress	Provider has opened their attestation and is actively editing it.
Submitted	Submitted	This status appears after submission for 48 hrs till final provider eligibility check is run. Provider can cancel an attestation and re-edit it for 2 days after submission prior to it being "finalized"
Pended	Pended	Provider sees "Pended"
Provider has failed final Elg check • POS Error • Volume error • Pay hold error	Resubmit	Provider sees "Resubmit" and the appropriate reason message for the eligibility error
Accepted	Accepted	Provider will see their attestation on the Status tab. The status will be Accepted
• Locked for Payment • Excluded from payment	Locked For Payment Excluded From Payment	Attestation remains on the Status tab only. Waiting for payment validation from NLR

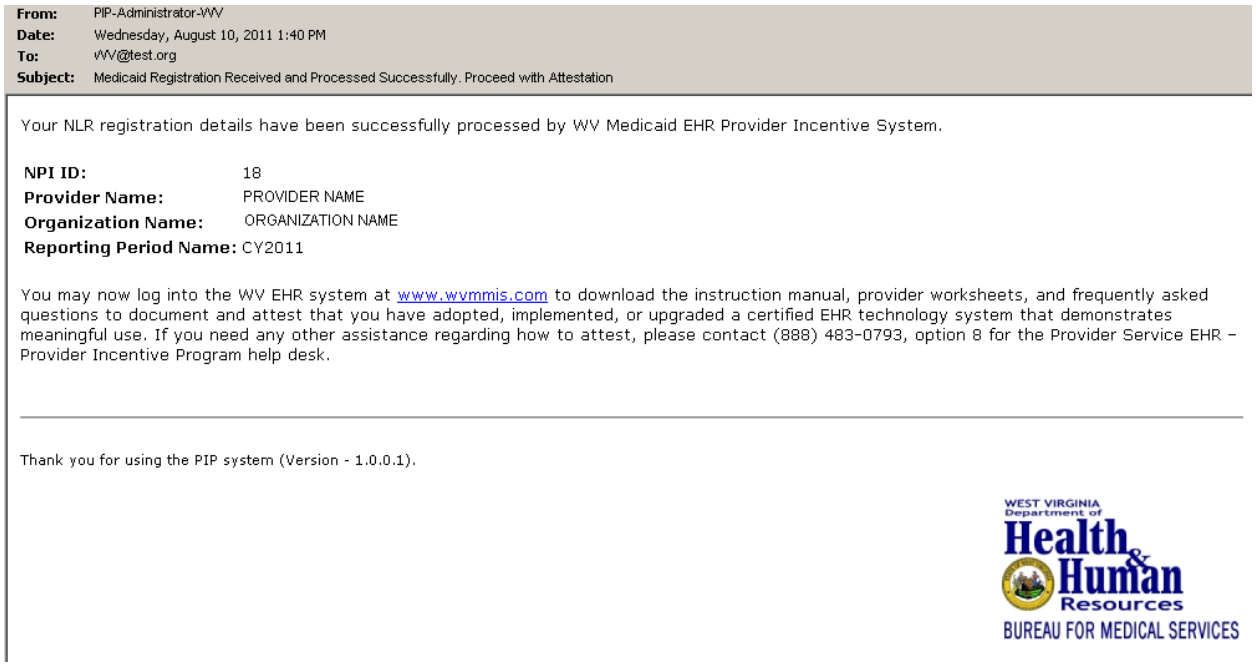
Figure 45 – Attestation Status

11. Successful Registration with CMS Email

After registering with CMS, it may take 48 hours before this message is received.

- The delay is for CMS processing registration and sending them to the appropriate State repository. The Provider Portal application will have the registration in this State repository and process registration. The Provider Portal application checks that the provider is a valid provider type and has active enrollment in Medicaid.

When this message is received, log into the Provider Portal to register and attest for this provider.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org
Subject: Medicaid Registration Received and Processed Successfully. Proceed with Attestation

Your NLR registration details have been successfully processed by WV Medicaid EHR Provider Incentive System.

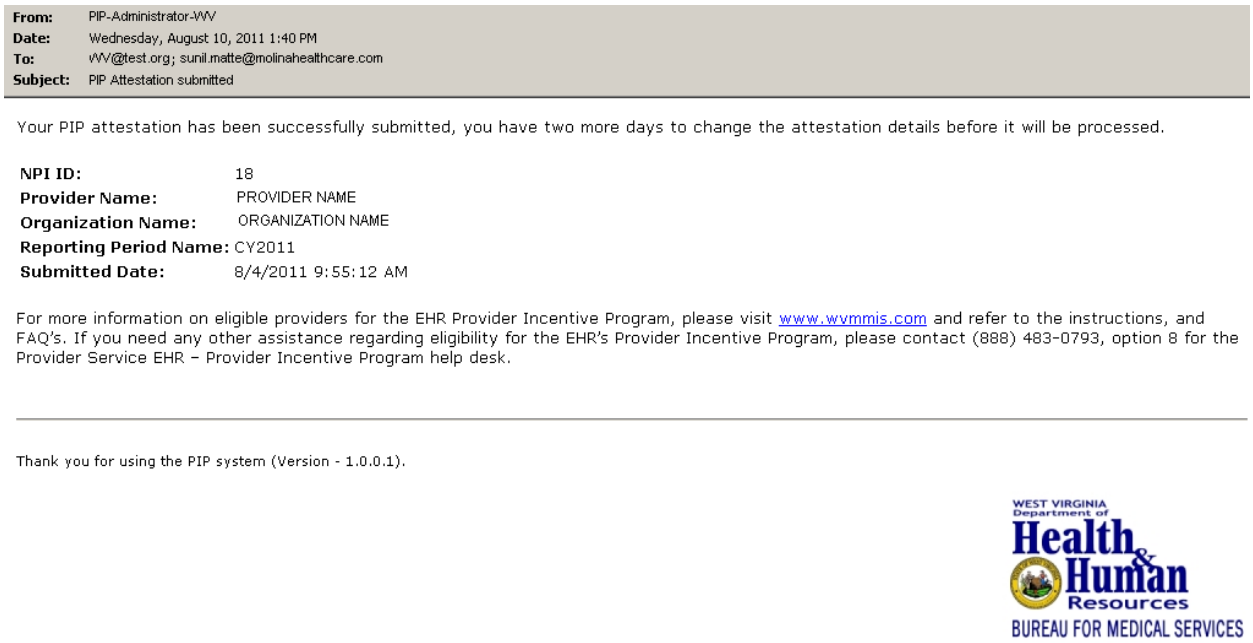
NPI ID: 18
Provider Name: PROVIDER NAME
Organization Name: ORGANIZATION NAME
Reporting Period Name: CY2011

You may now log into the WV EHR system at www.wvmmis.com to download the instruction manual, provider worksheets, and frequently asked questions to document and attest that you have adopted, implemented, or upgraded a certified EHR technology system that demonstrates meaningful use. If you need any other assistance regarding how to attest, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

12. Submitted Attestation Email

This email is sent after submitting the attestation. The system will wait two days to provide time for modifications. After the two days have passed, the system will execute the final edits.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org; sunil.matte@molinahealthcare.com
Subject: PIP Attestation submitted

Your PIP attestation has been successfully submitted, you have two more days to change the attestation details before it will be processed.

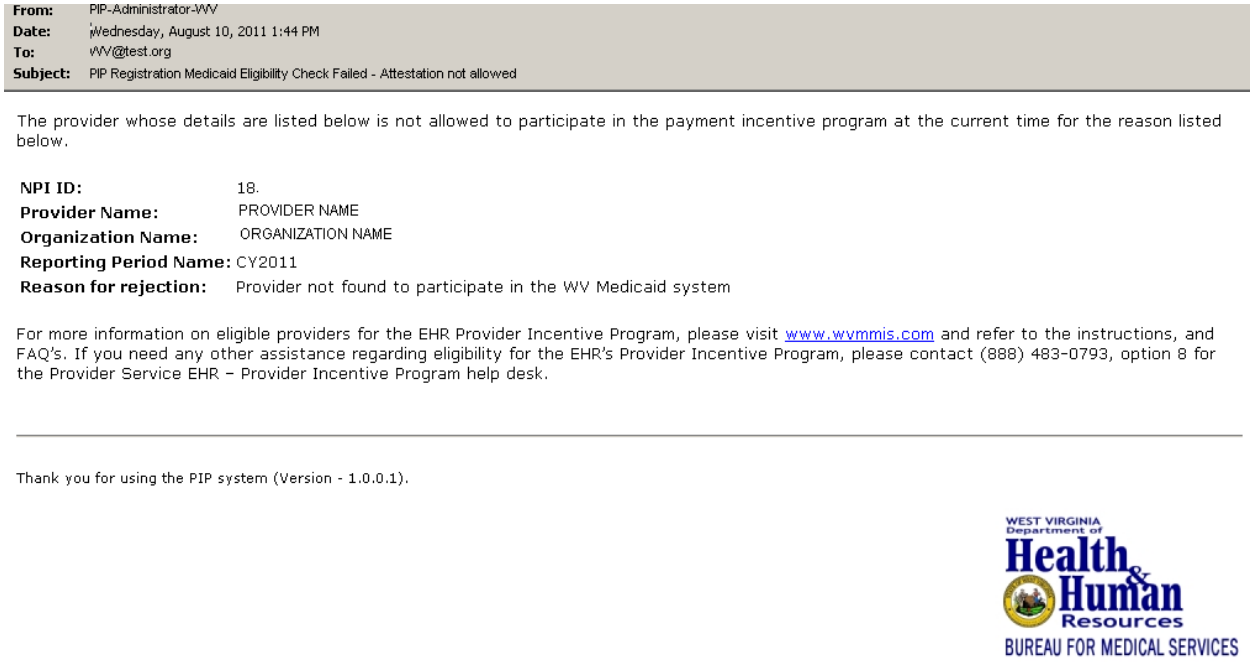
NPI ID:	18
Provider Name:	PROVIDER NAME
Organization Name:	ORGANIZATION NAME
Reporting Period Name:	CY2011
Submitted Date:	8/4/2011 9:55:12 AM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

13. Error Occurred When Processing Registration Email

When the registration arrives from the NLR to the application, validation of the provider is required. This email occurs if the provider does not exist in the MMIS.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:44 PM
To: WV@test.org
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.

NPI ID: 18.
Provider Name: PROVIDER NAME
Organization Name: ORGANIZATION NAME
Reporting Period Name: CY2011
Reason for rejection: Provider not found to participate in the WV Medicaid system

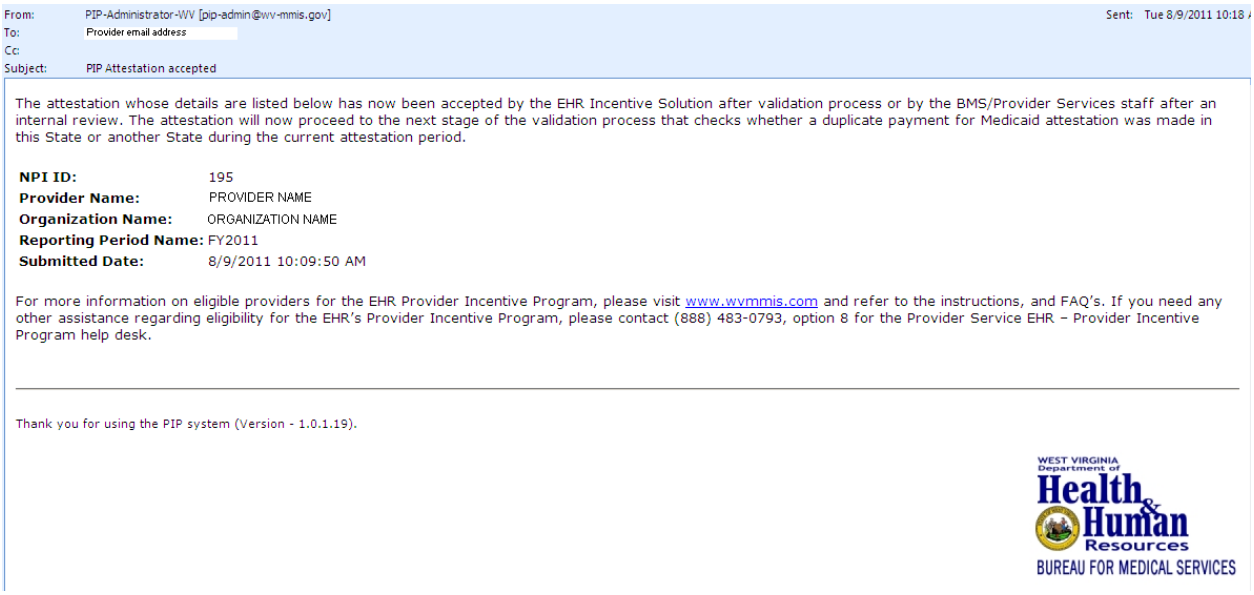
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

14. Attestation Accepted Email

This email is sent when either one of the two scenarios occur.

- The 48 hour time span that allowed for changes has expired. The attestation is no longer accessible for changes within the application. The attestation details will be sent to the NLR to check if any payments have been made for the attesting provider.
- BMS has reviewed the failed attestation details and found that the attestation is acceptable. BMS set the status to an accepted status. The attestations details will be sent to the NLR to check if any payments have been made for the attesting provider.



From: PIP-Administrator-WV [pip-admin@wv-mmis.gov] Sent: Tue 8/9/2011 10:18 A
To: Provider email address
Cc:
Subject: PIP Attestation accepted

The attestation whose details are listed below has now been accepted by the EHR Incentive Solution after validation process or by the BMS/Provider Services staff after an internal review. The attestation will now proceed to the next stage of the validation process that checks whether a duplicate payment for Medicaid attestation was made in this State or another State during the current attestation period.

NPI ID: 195
Provider Name: PROVIDER NAME
Organization Name: ORGANIZATION NAME
Reporting Period Name: FY2011
Submitted Date: 8/9/2011 10:09:50 AM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

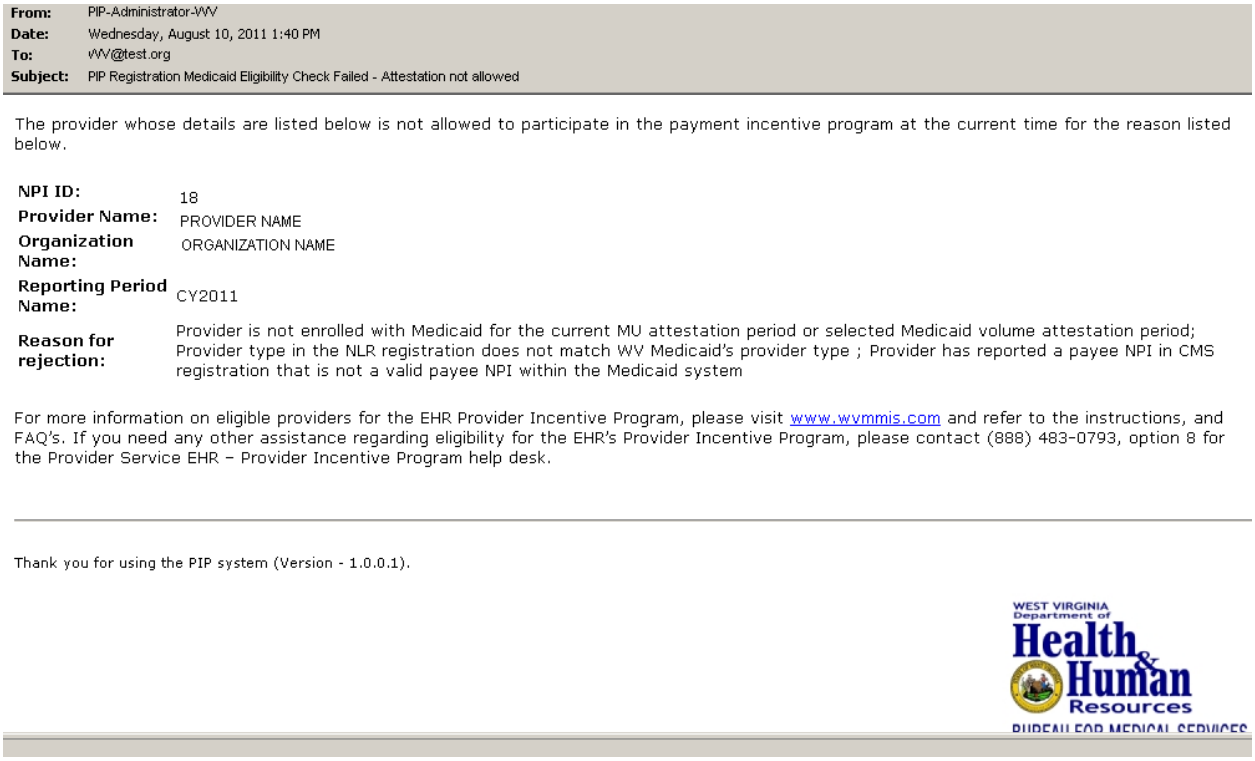
Thank you for using the PIP system (Version - 1.0.1.19).

WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR MEDICAL SERVICES

15. Error Occurred While Processing Registration – Medicaid Enrollment Failed Email

The following checks are made when an attestation is received from the NLR. The email below displays all the possible error messages for the following checks.

- Check if the provider is enrolled in Medicaid program during the attestation period.
- Check if the provider type that was selected when registering on the CMS site matches the provider type on the provider's enrollment record.
- Check if the payee NPI entered when registering on the CMS site is found when validating the attesting provider's payees on the Medicaid record.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.

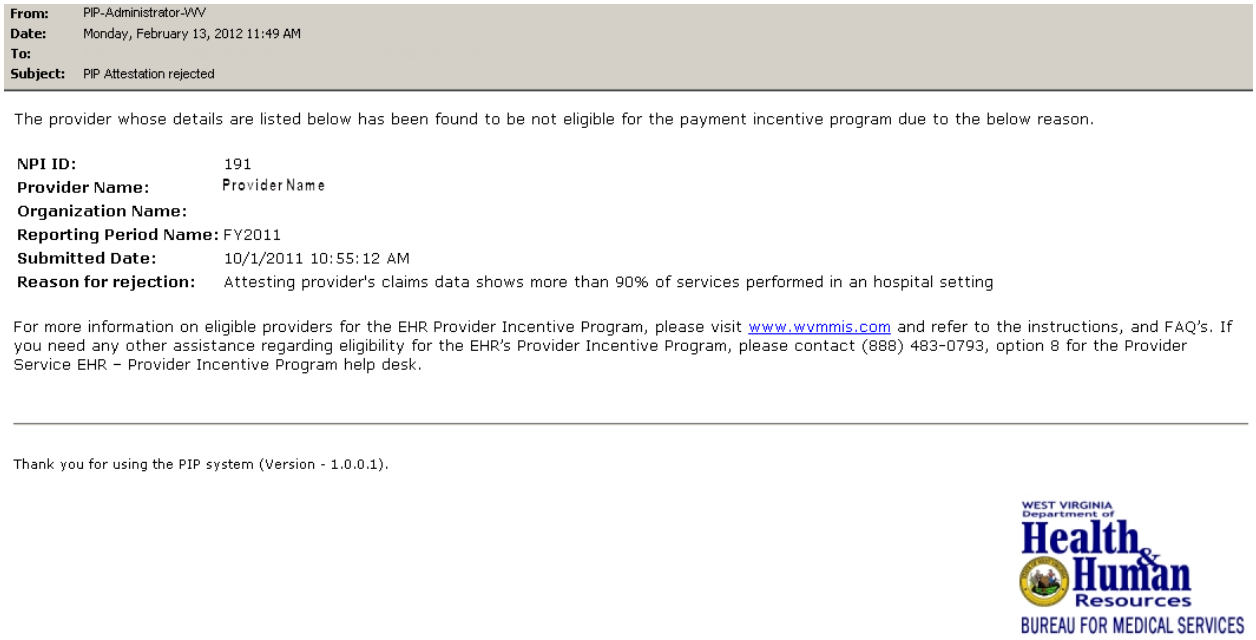
NPI ID:	18
Provider Name:	PROVIDER NAME
Organization Name:	ORGANIZATION NAME
Reporting Period Name:	CY2011
Reason for rejection:	Provider is not enrolled with Medicaid for the current MU attestation period or selected Medicaid volume attestation period; Provider type in the NLR registration does not match WV Medicaid's provider type ; Provider has reported a payee NPI in CMS registration that is not a valid payee NPI within the Medicaid system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

16. Attestation Error – Practice Predominately in a Hospital Setting Email

Claims checks are part of the processing. If it was found that the provider practiced predominately in a hospital, the attestation is ineligible and the email is sent.



From: PIP-Administrator-WV
Date: Monday, February 13, 2012 11:49 AM
To:
Subject: PIP Attestation rejected

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID: 191
Provider Name: Provider Name
Organization Name:
Reporting Period Name: FY2011
Submitted Date: 10/1/2011 10:55:12 AM
Reason for rejection: Attesting provider's claims data shows more than 90% of services performed in an hospital setting

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

17. Attestation Error – Medicaid Claims Count Failed Email

The solution will check the provider's Medicaid claims that were submitted during the attestation period. If there were no claims found for the attestation period, the following email will be sent.

From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org; sunil.matte@molinahealthcare.com
Subject: PIP Attestation rejected

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID:	18
Provider Name:	PROVIDER NAME
Organization Name:	ORGANIZATION NAME
Reporting Period Name:	CY2011
Submitted Date:	8/4/2011 9:55:12 AM
Reason for rejection:	Provider has no Medicaid claims in the State's Medicaid system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

If the solution found that claims counts could not be validated, then the following email is sent.

From: PIP-Administrator-WV
Date: Monday, February 13, 2012 11:49 AM
To:
Subject: PIP Attestation rejected

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

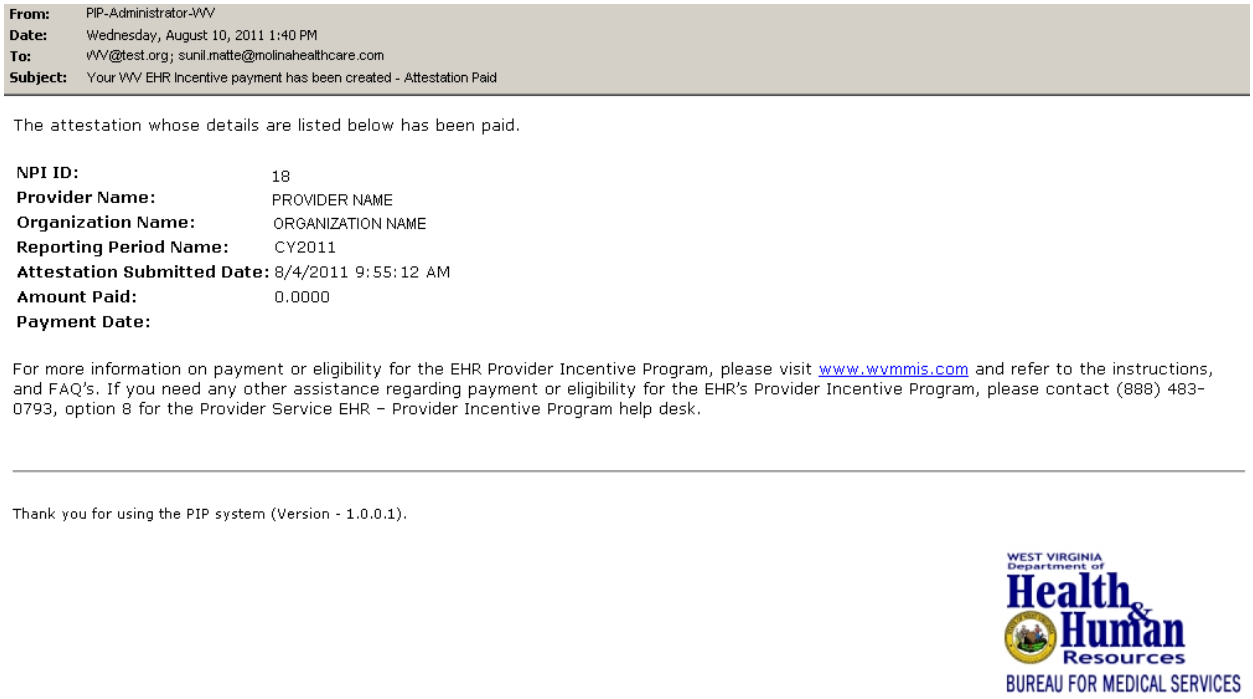
NPI ID:	19
Provider Name:	Provider Name
Organization Name:	
Reporting Period Name:	FY2011
Submitted Date:	10/1/2011 10:55:12 AM
Reason for rejection:	Medicaid Encounter volume is not able to be validated by the state's EHR Provider Incentive Payment solution's encounter count for the provider or their proxy within the MMIS system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

18. Attestation Paid Email

If final eligibility checks pass and no payment issues occurred, an email is sent indicating that payment is approved and being processed. The payment will continue with additional processing, so payment arrival will take a few days.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org; sunil.matte@molinahealthcare.com
Subject: Your WV EHR Incentive payment has been created - Attestation Paid

The attestation whose details are listed below has been paid.

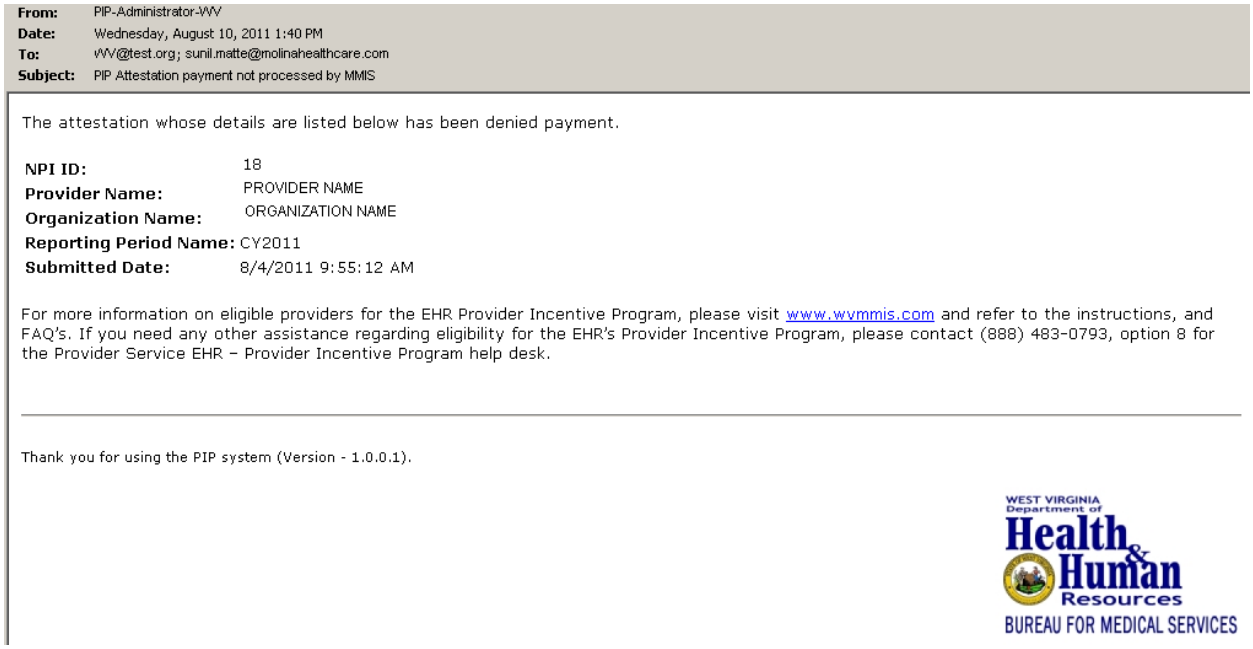
NPI ID:	18
Provider Name:	PROVIDER NAME
Organization Name:	ORGANIZATION NAME
Reporting Period Name:	CY2011
Attestation Submitted Date:	8/4/2011 9:55:12 AM
Amount Paid:	0.0000
Payment Date:	

For more information on payment or eligibility for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding payment or eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

19. Attestation Payment Denied Email

If final eligibility checks did not pass and payment issues occurred, an email indicating denial is sent. The Medicaid Provider Services staff at 1-888-483-0793, option 8 may be able to address questions.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org; sunil.matte@molinahealthcare.com
Subject: PIP Attestation payment not processed by MMIS

The attestation whose details are listed below has been denied payment.

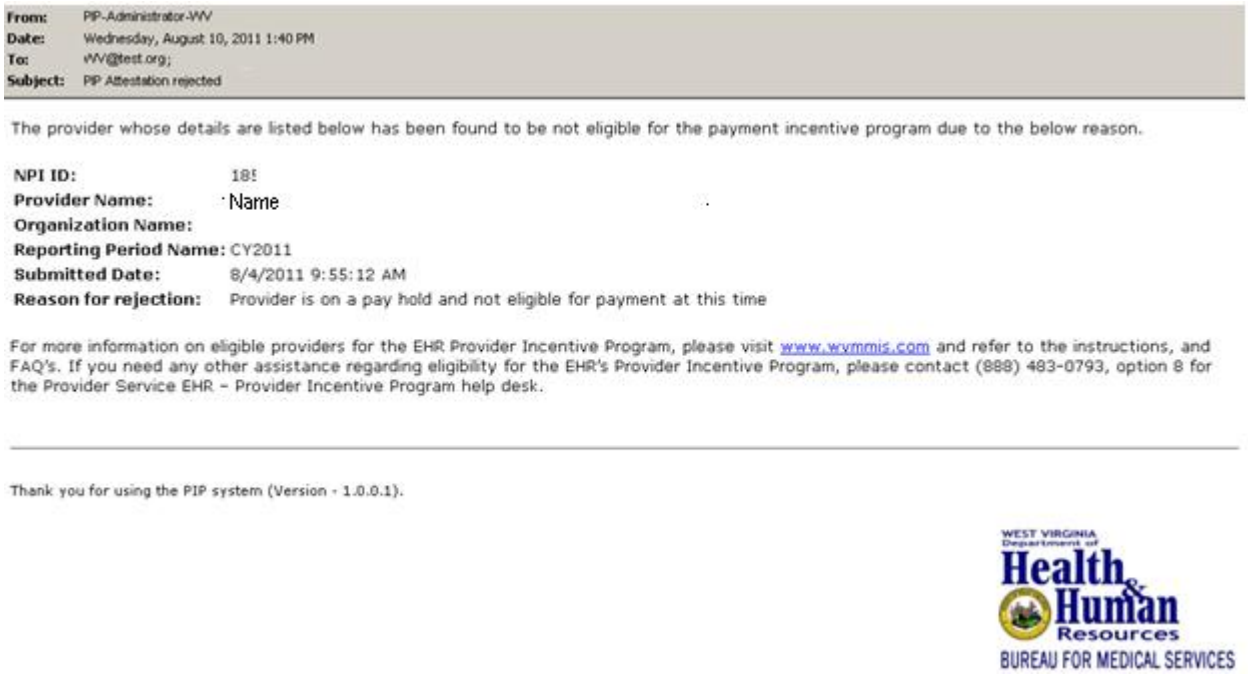
NPI ID: 18
Provider Name: PROVIDER NAME
Organization Name: ORGANIZATION NAME
Reporting Period Name: CY2011
Submitted Date: 8/4/2011 9:55:12 AM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

20. Attestation Payment Denied – Pay Hold Found

Payment is denied if the provider is on pay hold and this email is sent if it is found.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org;
Subject: PIP Attestation rejected

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID: 18!
Provider Name: Name
Organization Name:
Reporting Period Name: CY2011
Submitted Date: 8/4/2011 9:55:12 AM
Reason for rejection: Provider is on a pay hold and not eligible for payment at this time

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

21. Attestation Excluded from Payment Email

This email indicates that CMS has already has a payment on record from this provider. Please contact the CMS NLR for questions and concerns.

From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org; sunil.matte@molinahealthcare.com
Subject: PIP Attestation excluded from payment

The attestation whose details are listed below has been excluded from payment by CMS due to a record of duplicate payment for Medicaid attestation in this State or another State during the current attestation period. If you think your payment is not duplicated at the national level, please work with the NLR to resolve.

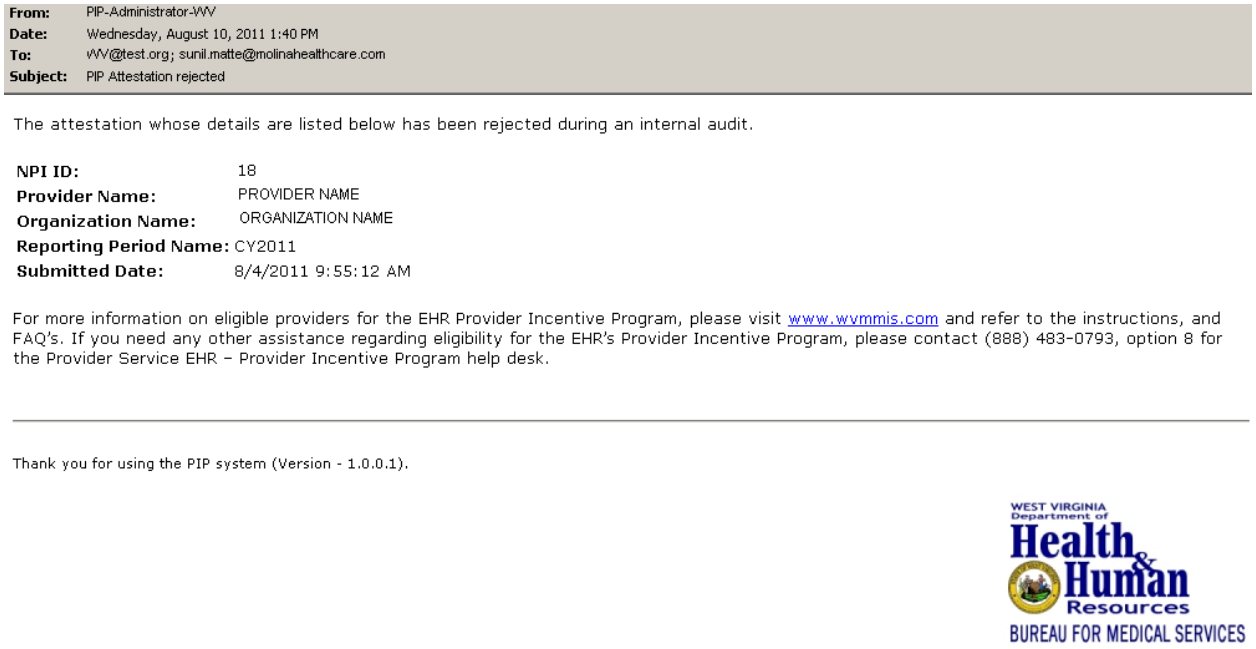
NPI ID:	18
Provider Name:	PROVIDER NAME
Organization Name:	ORGANIZATION NAME
Reporting Period Name:	CY2011
Attestation Submitted Date:	8/4/2011 9:55:12 AM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

22. Attestation Rejected Email

WV Medicaid and WV Medicaid Provider Services staff has the ability to review attestation and reject a submitted attestation. When the attestation is rejected, an email is sent to notify the user of the status change. To find out more information, please contact the Medicaid Provider Services staff at 1-888-483-0793, option 8.



From: PIP-Administrator-WV
Date: Wednesday, August 10, 2011 1:40 PM
To: WV@test.org; sunil.matte@molinahealthcare.com
Subject: PIP Attestation rejected

The attestation whose details are listed below has been rejected during an internal audit.

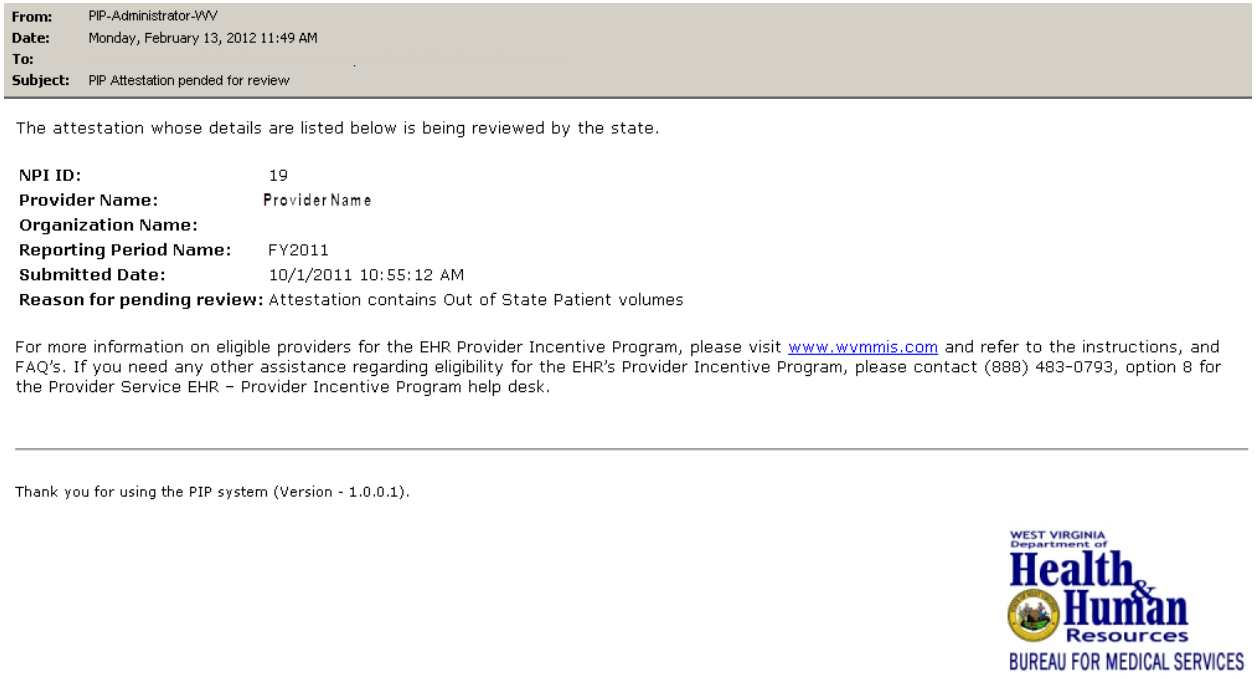
NPI ID:	18
Provider Name:	PROVIDER NAME
Organization Name:	ORGANIZATION NAME
Reporting Period Name:	CY2011
Submitted Date:	8/4/2011 9:55:12 AM

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

23. Attestation Pended for Out-of-State Entries

If a submitted attestation has passed volume checks and has OOS entries, the attestation will be Pended. The WV Medicaid and WV Medicaid Provider Services staff will review the required documentation and determine if the attestation is acceptable. The following email indicates that the attestation was Pended. To find out more information, please contact the Medicaid Provider Services staff at 1-888-483-0793, Option 8.



From: PIP-Administrator-WV
Date: Monday, February 13, 2012 11:49 AM
To:
Subject: PIP Attestation pended for review

The attestation whose details are listed below is being reviewed by the state.

NPI ID: 19
Provider Name: Provider Name
Organization Name:
Reporting Period Name: FY2011
Submitted Date: 10/1/2011 10:55:12 AM
Reason for pending review: Attestation contains Out of State Patient volumes

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

24. Attestation Failed Meaningful Use

After the provider attestation passes the volume check and payment checks, the application will validate that the Meaningful Use Core and Menu Measures responses meant or exceed the required response. If the user failed one or more questions, the following email will be sent to notify that Meaningful Use failed.

From: EHR-Administrator Sent: Fri :2 10:5
To:
Cc:
Subject: EHR Incentive Program Attestation rejected

The provider whose details are listed below has been found to be not eligible for the EHR Incentive Program due to the below reason.

NPI ID:
Provider Name:
Organization Name:
Reporting Period Name: CY2012
Submitted Date: 3/2/2012 10:38:39 AM
Reason for rejection: Failed Meaningful Use

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.wvmmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

25. Meaningful Use Core Measures Screen Shots

CMS requires a response to the 17 core measure questions. All possible screens are displayed below. The core question displays. However, the core question's supporting screens display is dependent on your response to the exclusion. An example of a supporting screen is the entry for numerator and Denominator, or to add results.

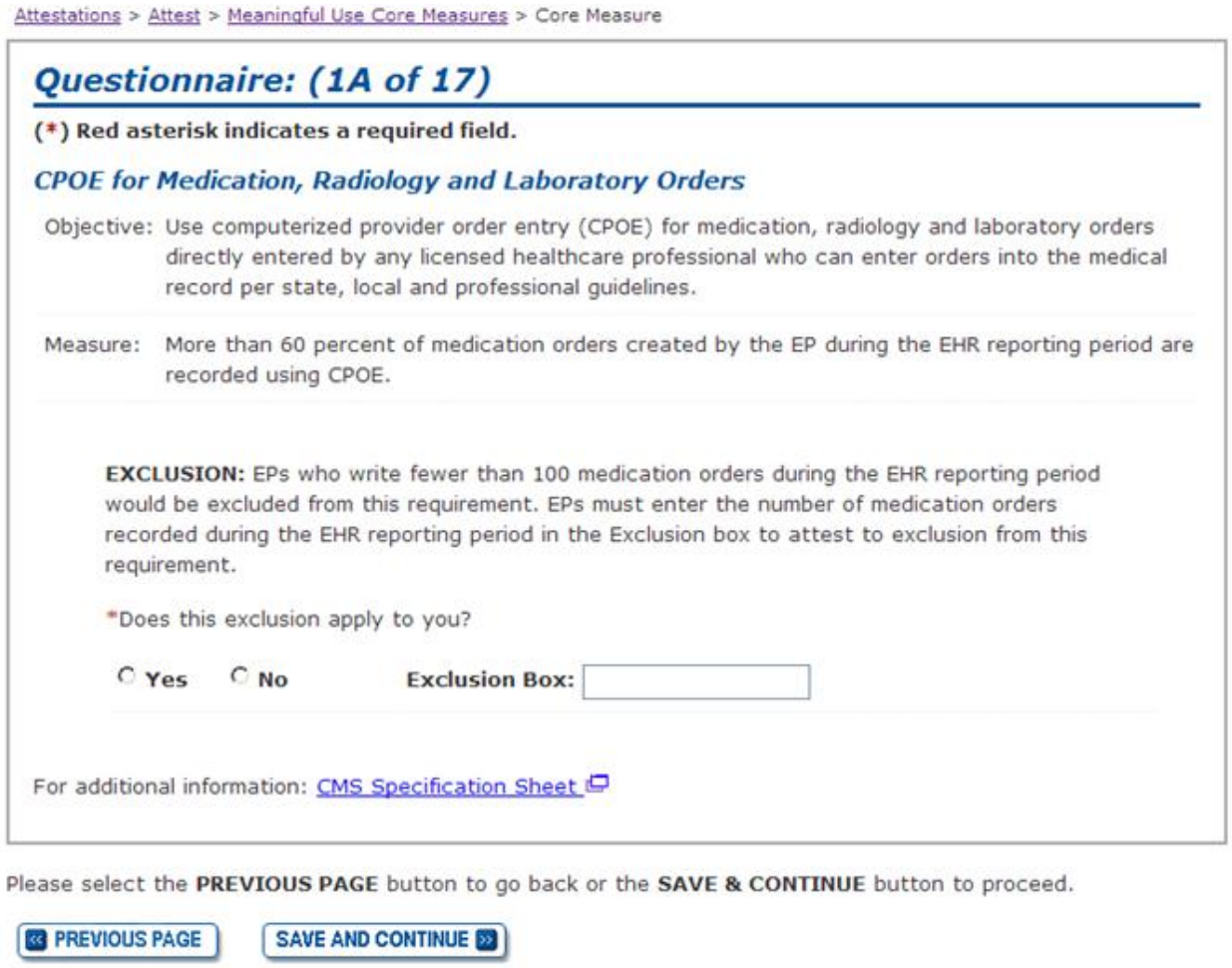


Figure 46 - MU Core Question 1A - CPOE for Medication, Radiology and Laboratory

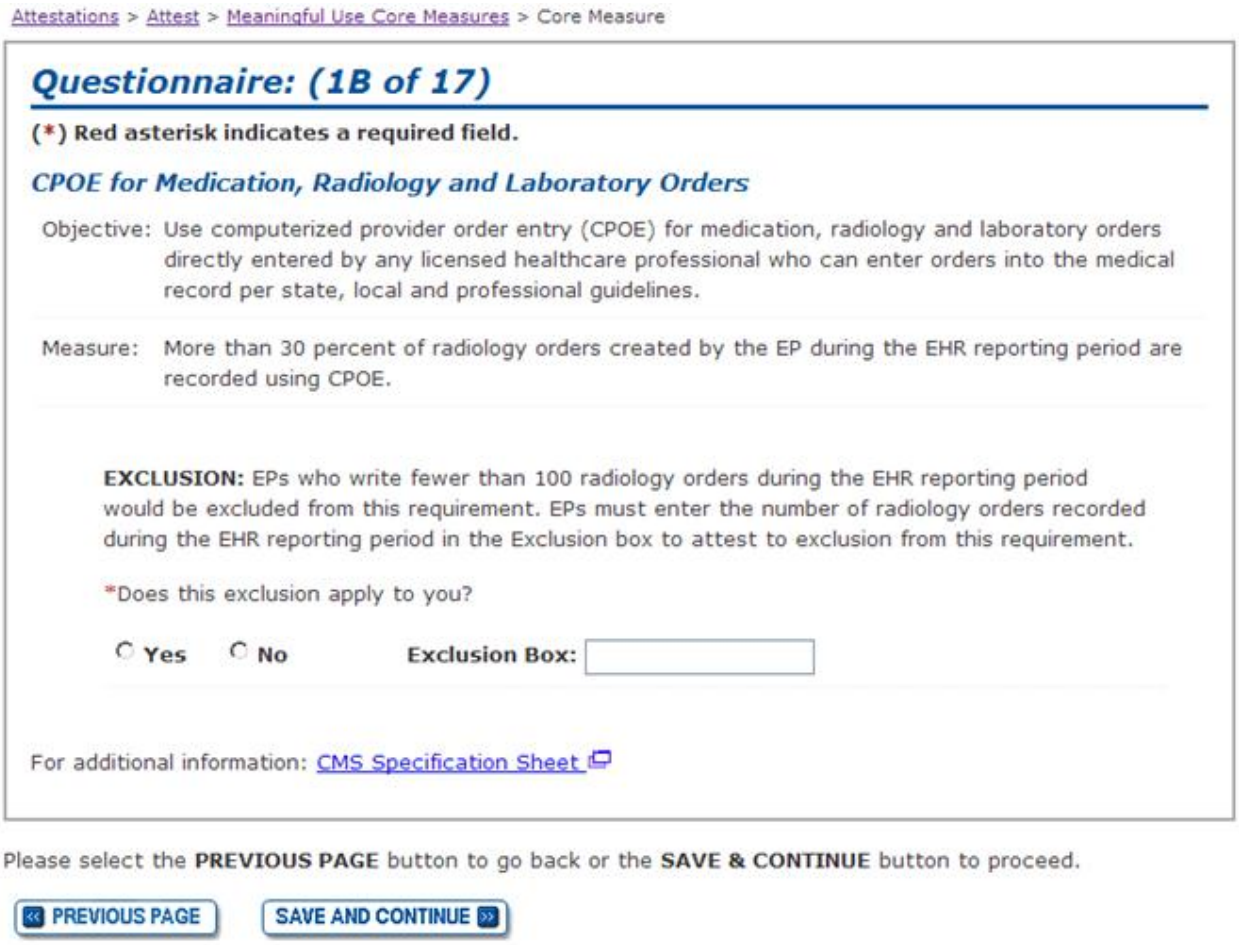


Figure 47 - MU Core Question 1B - CPOE for Medication, Radiology and Laboratory

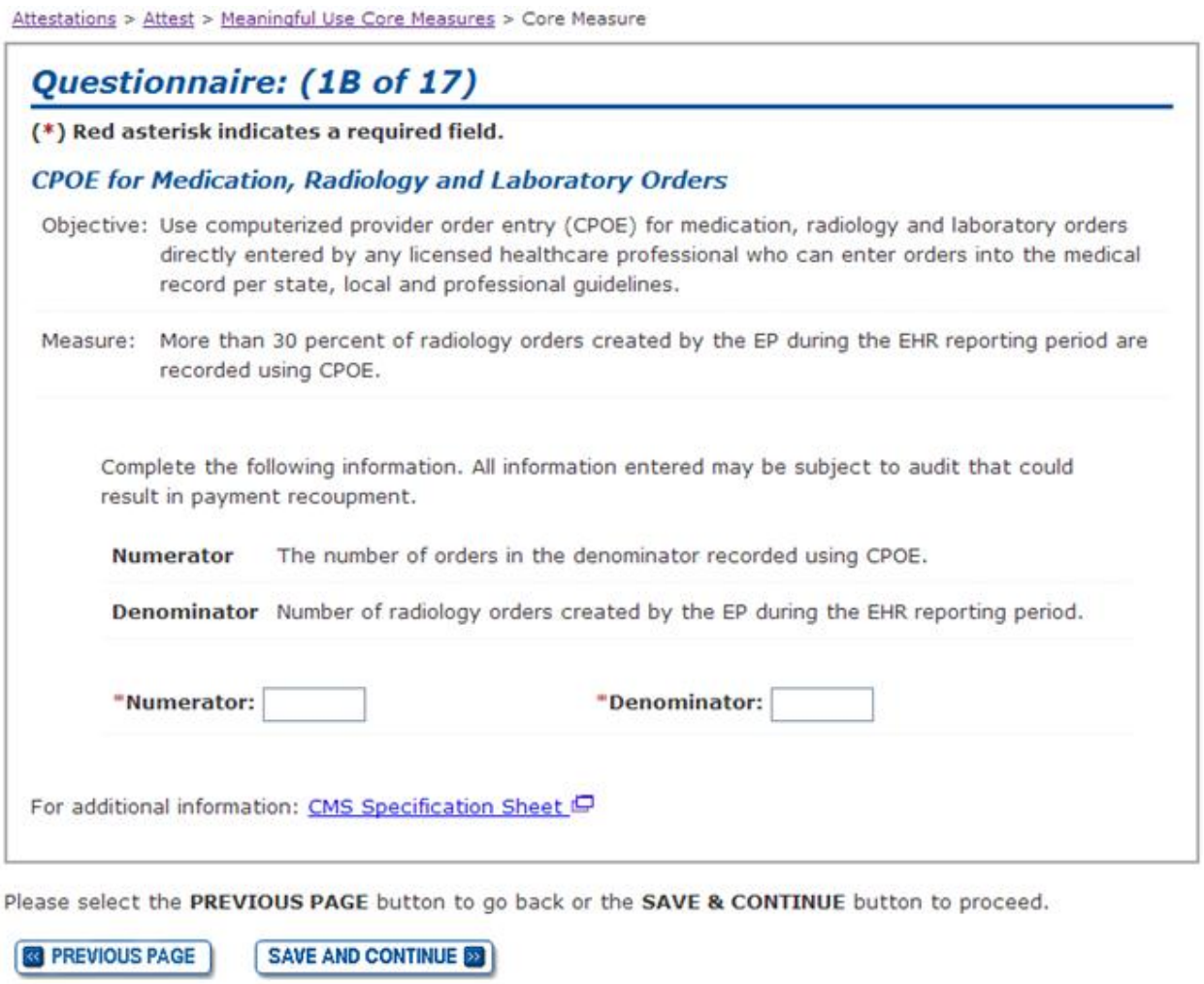


Figure 48 - MU Core Question 1B Numerator & Denominator Entry Screen

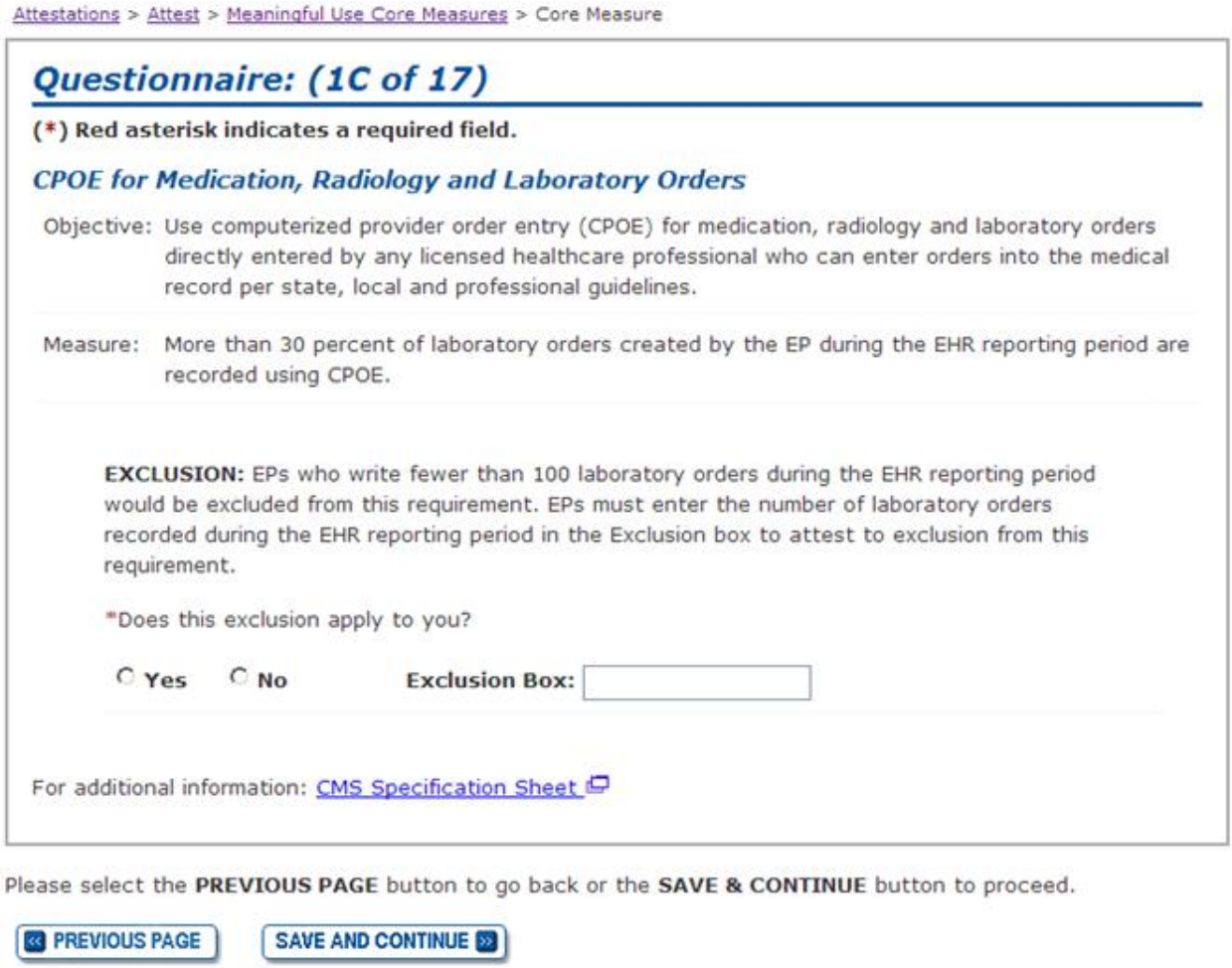


Figure 49 - MU Core 1C Question - CPOE Medication, Radiology and Laboratory Orders

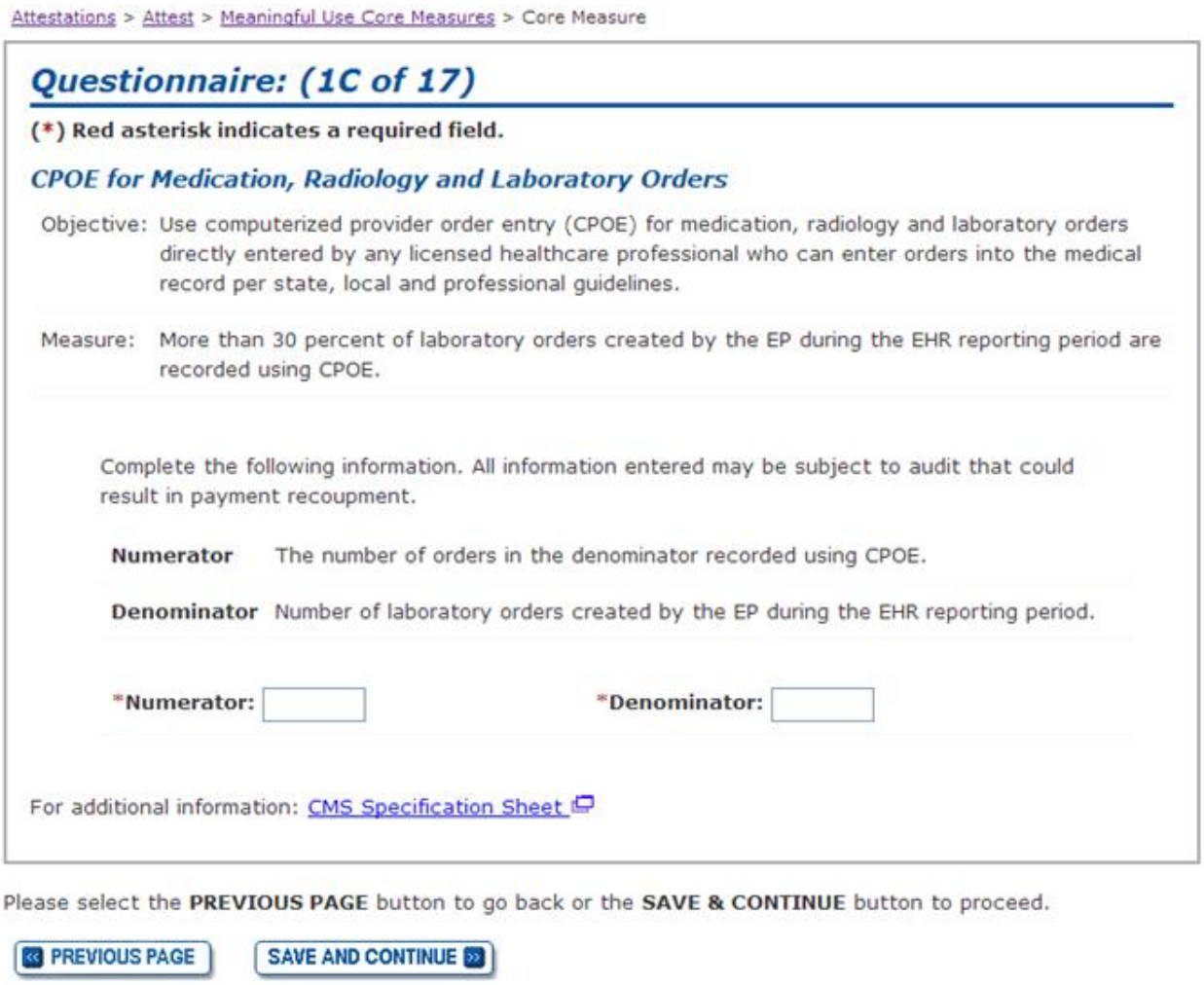


Figure 50 - MU Core 1C Numerator & Denominator Entry screen

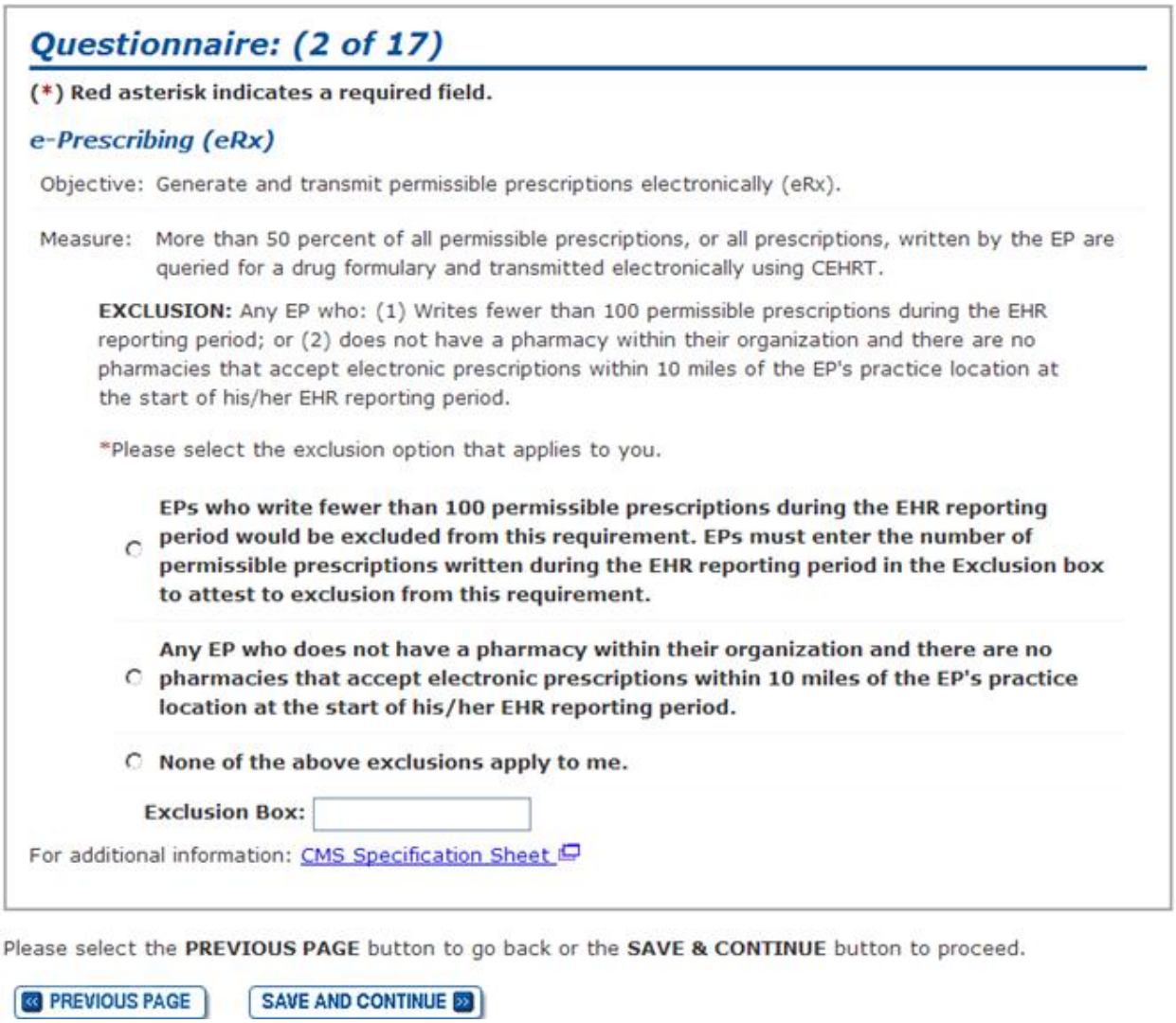


Figure 51 - MU Core Question 2 e-Prescribing (eRx)

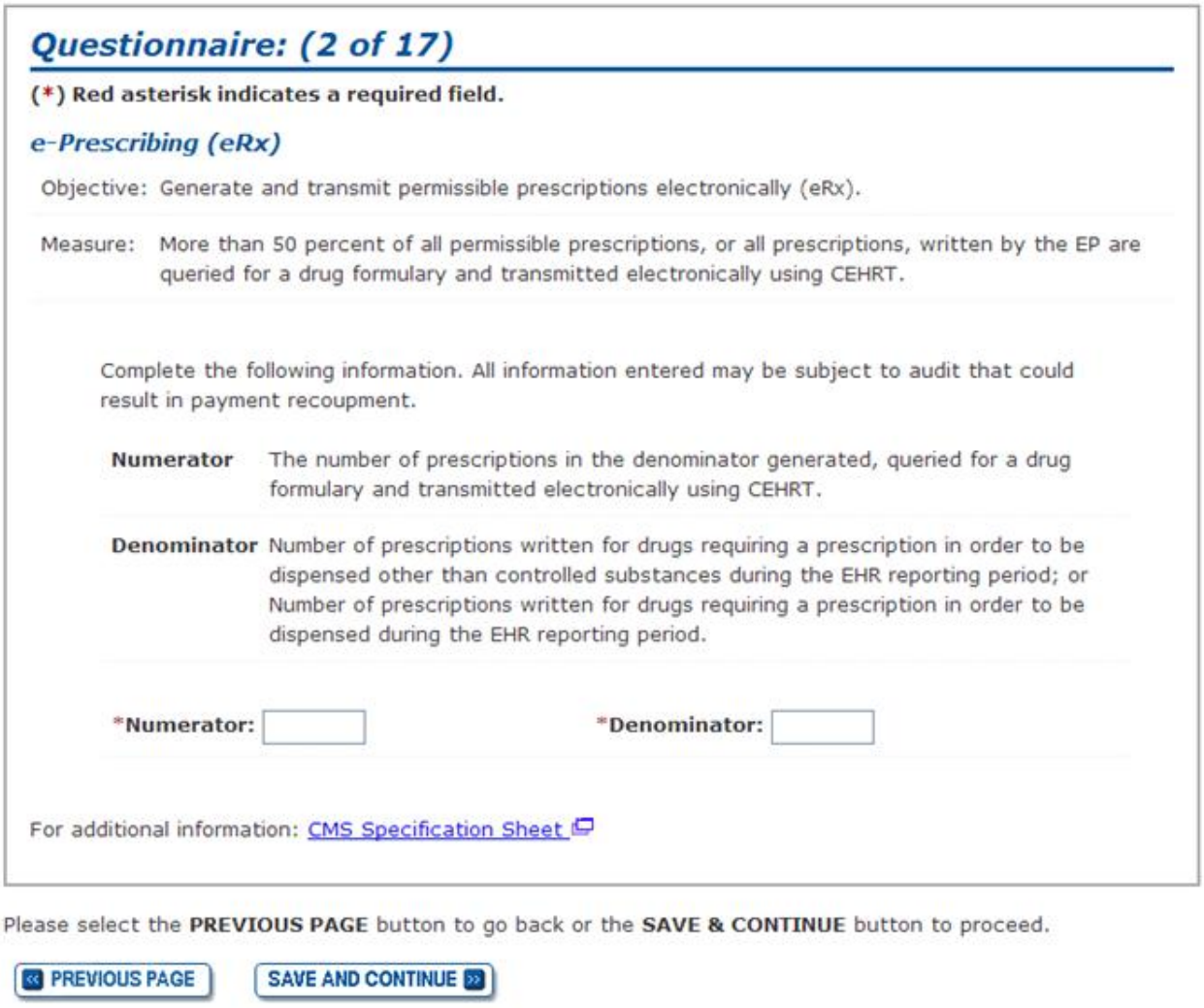


Figure 52 - MU Core Question 2 Numerator & Denominator Entry Screen

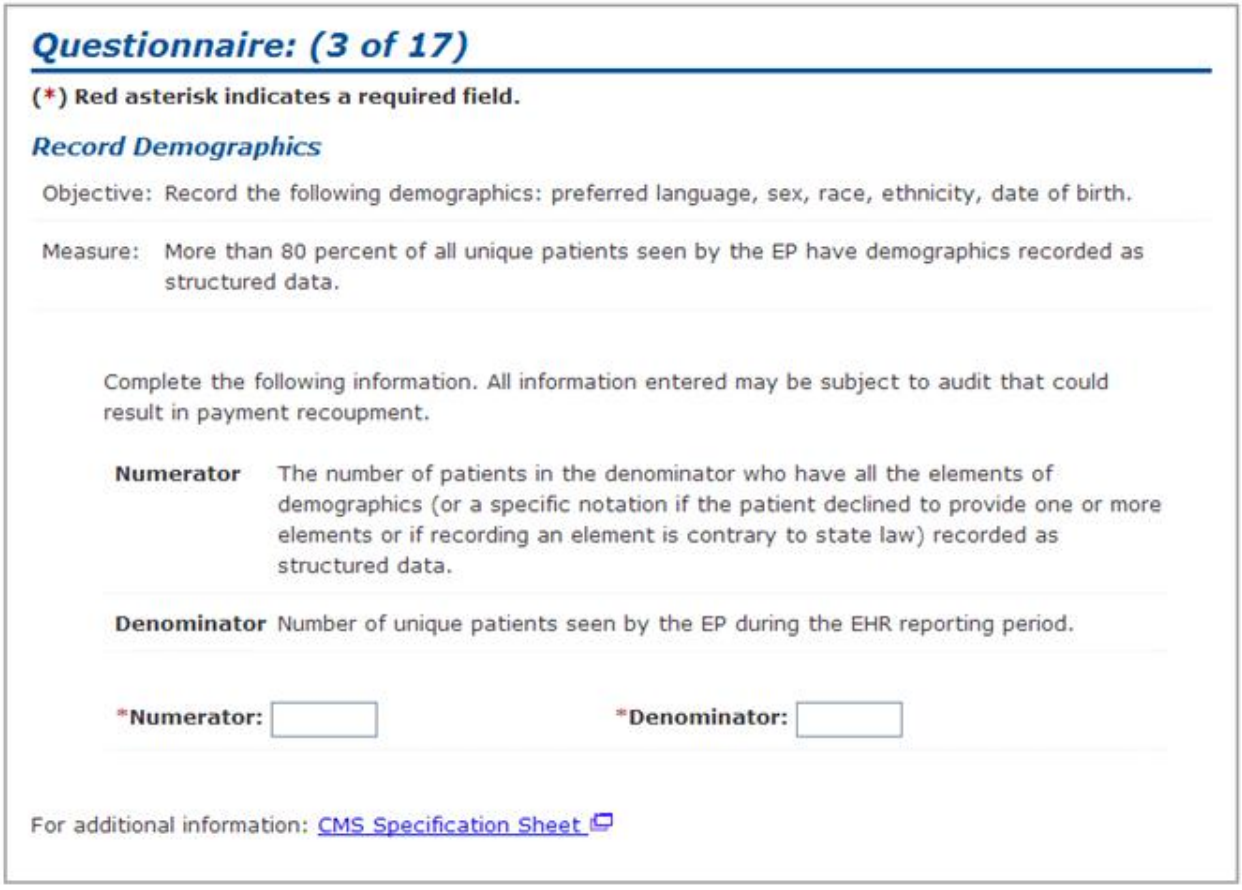
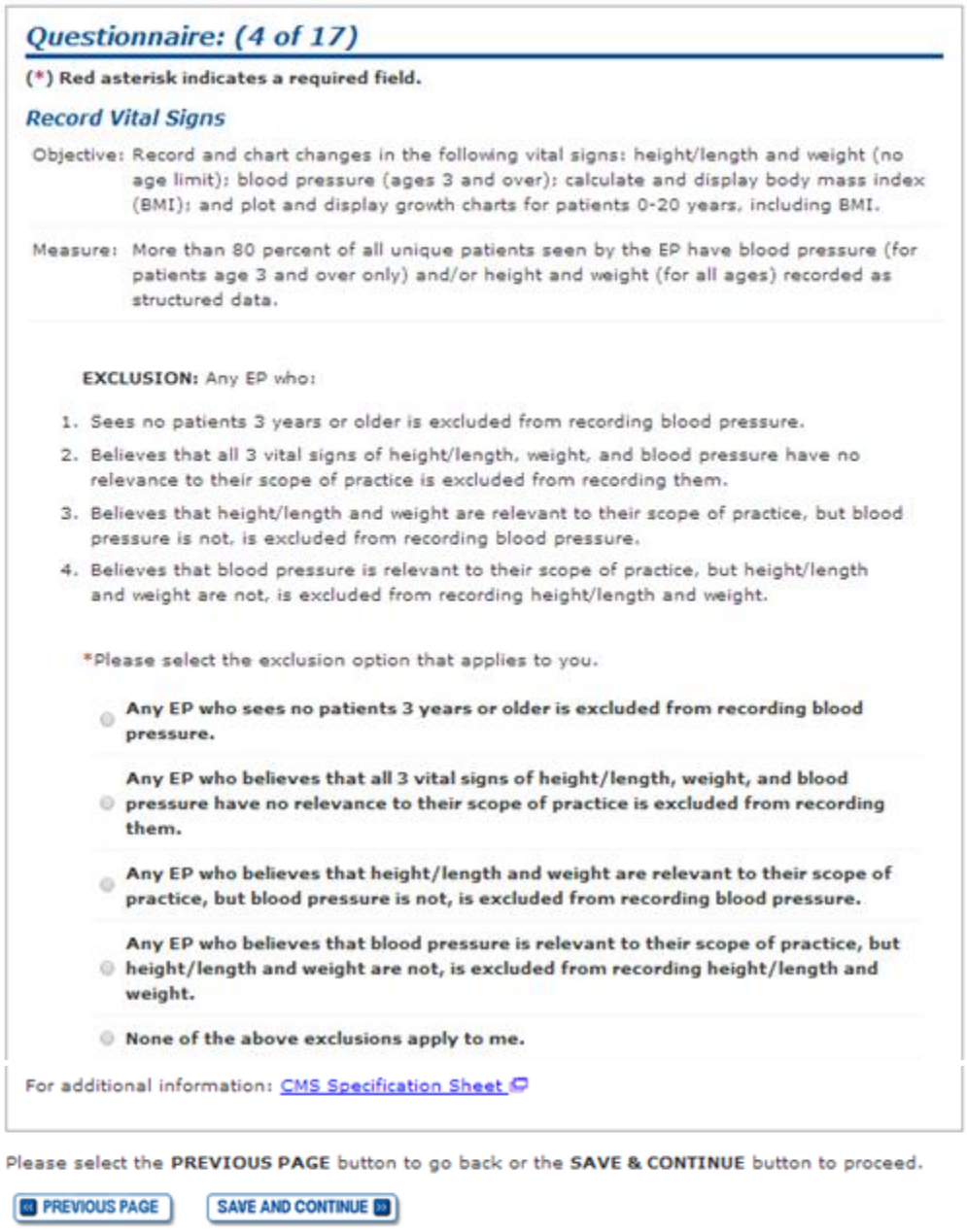


Figure 53 - MU Core Question 3 - Record Demographics



Questionnaire: (4 of 17)

(*) Red asterisk indicates a required field.

Record Vital Signs

Objective: Record and chart changes in the following vital signs: height/length and weight (no age limit); blood pressure (ages 3 and over); calculate and display body mass index (BMI); and plot and display growth charts for patients 0-20 years, including BMI.

Measure: More than 80 percent of all unique patients seen by the EP have blood pressure (for patients age 3 and over only) and/or height and weight (for all ages) recorded as structured data.

EXCLUSION: Any EP who:

1. Sees no patients 3 years or older is excluded from recording blood pressure.
2. Believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.
3. Believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
4. Believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.

*Please select the exclusion option that applies to you.

- **Any EP who sees no patients 3 years or older is excluded from recording blood pressure.**
- **Any EP who believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.**
- **Any EP who believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.**
- **Any EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.**
- **None of the above exclusions apply to me.**

For additional information: CMS Specification Sheet

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Figure 54 - MU Core Question 4 - Record Vital Signs

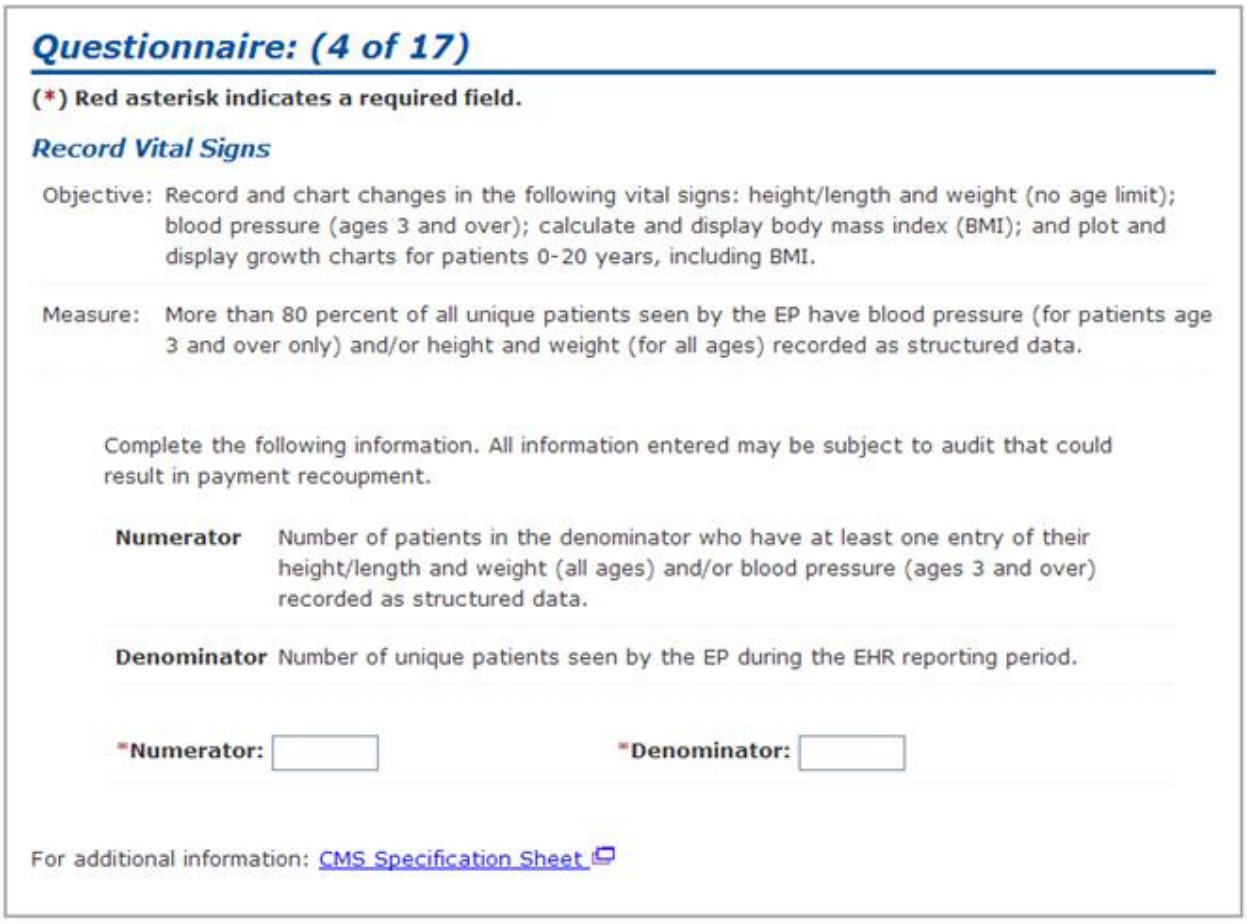


Figure 55 - MU Core Question 4 Numerator & Denominator Entry Screen

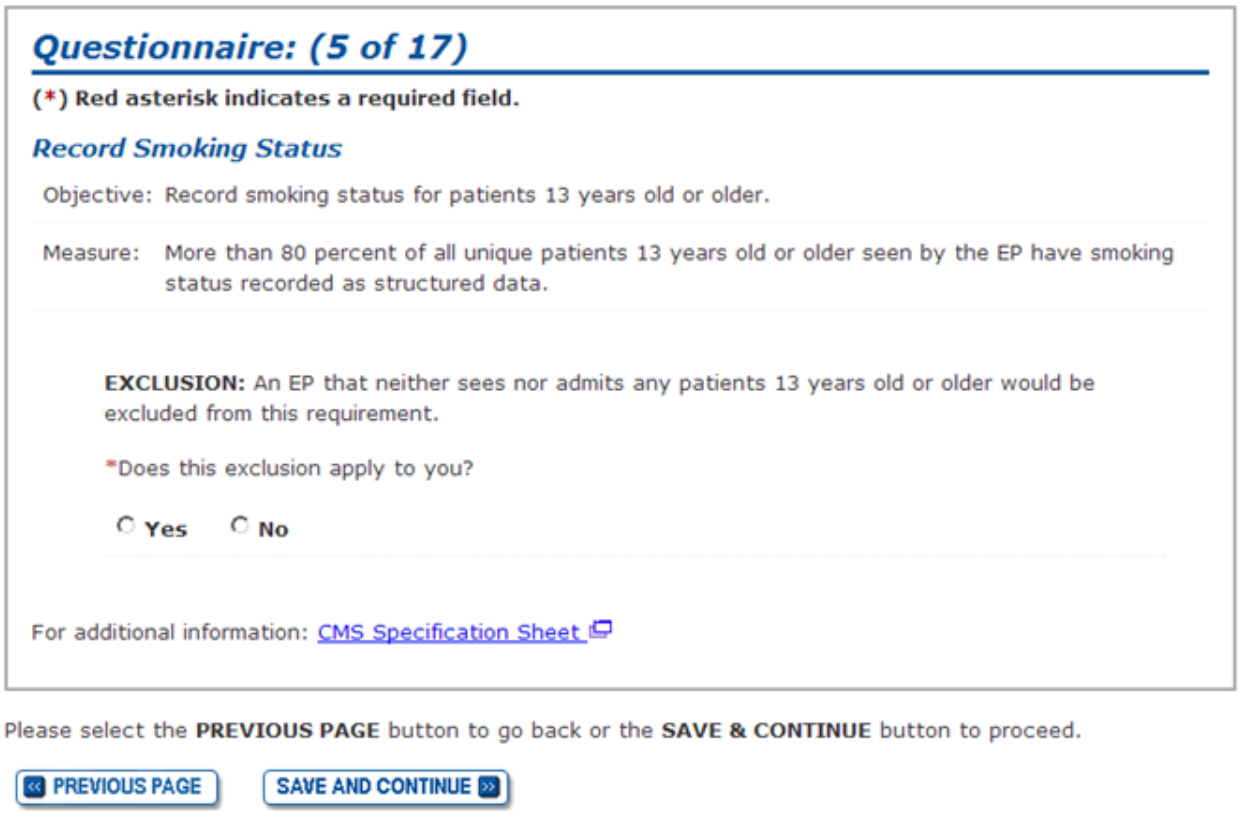


Figure 56 - MU Core Question 5 - Record Smoking Status

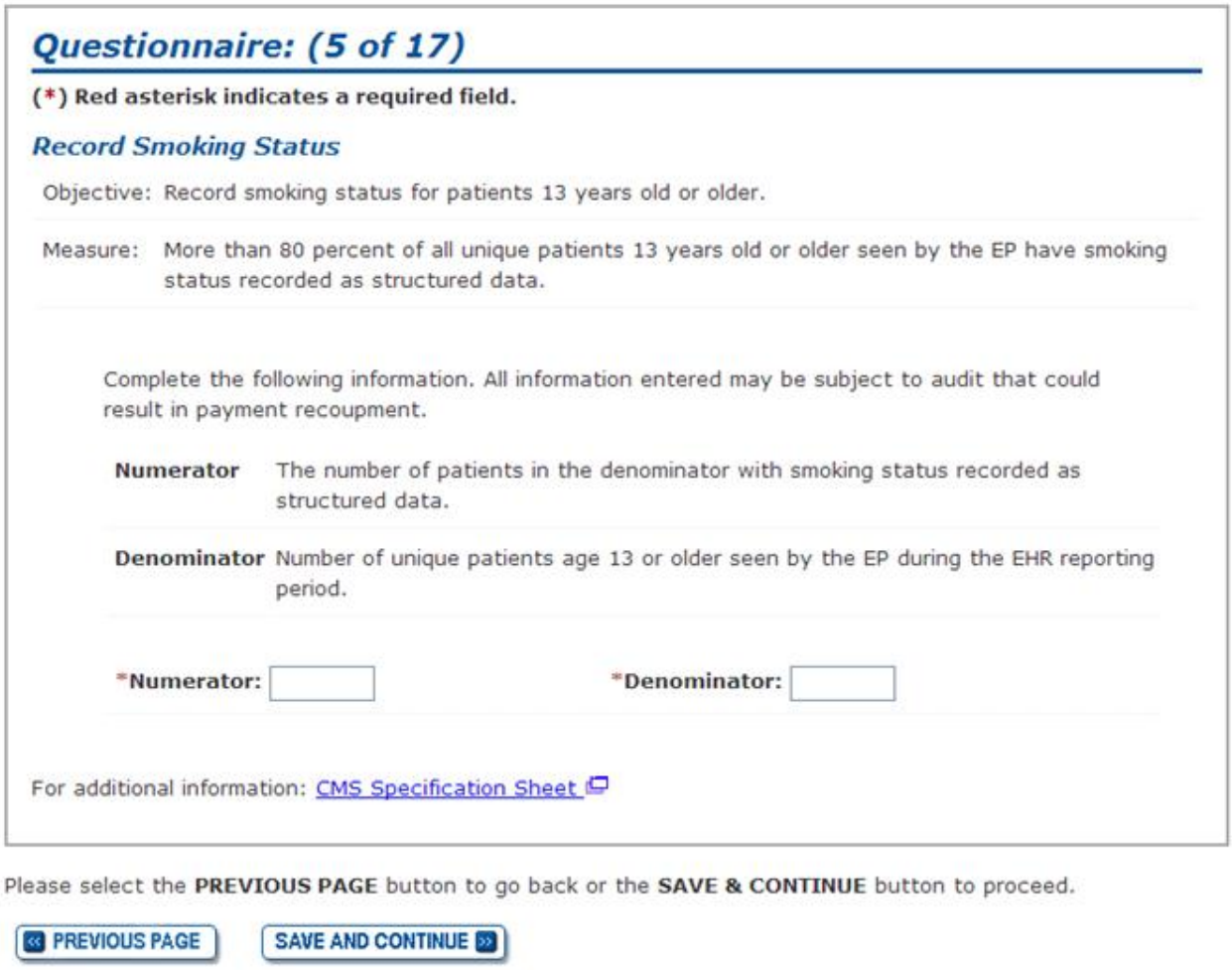


Figure 57- MU Core Question 5 Numerator & Denominator Entry Screen

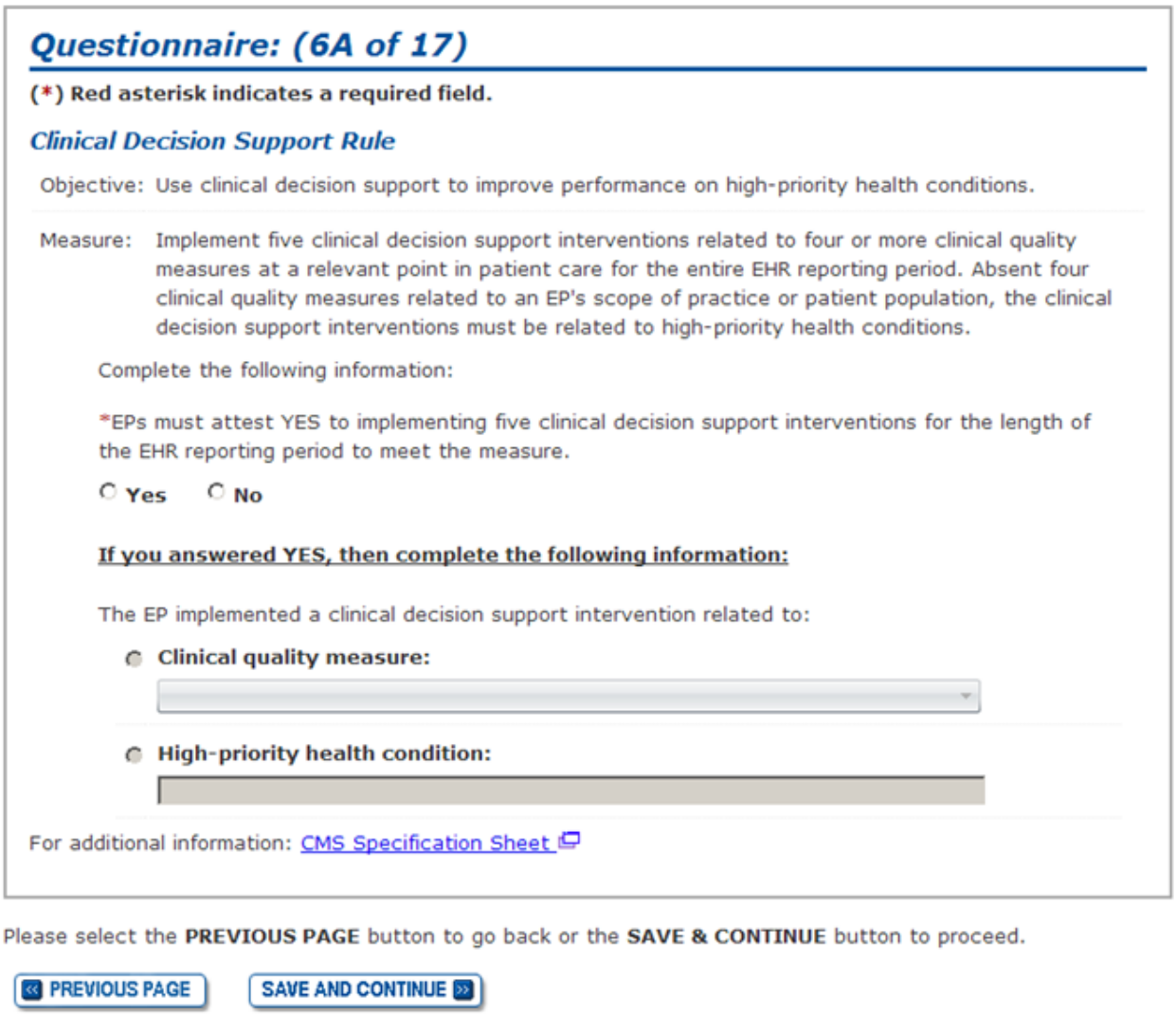


Figure 58 - MU Question 6A - Clinical Decision Support Rule

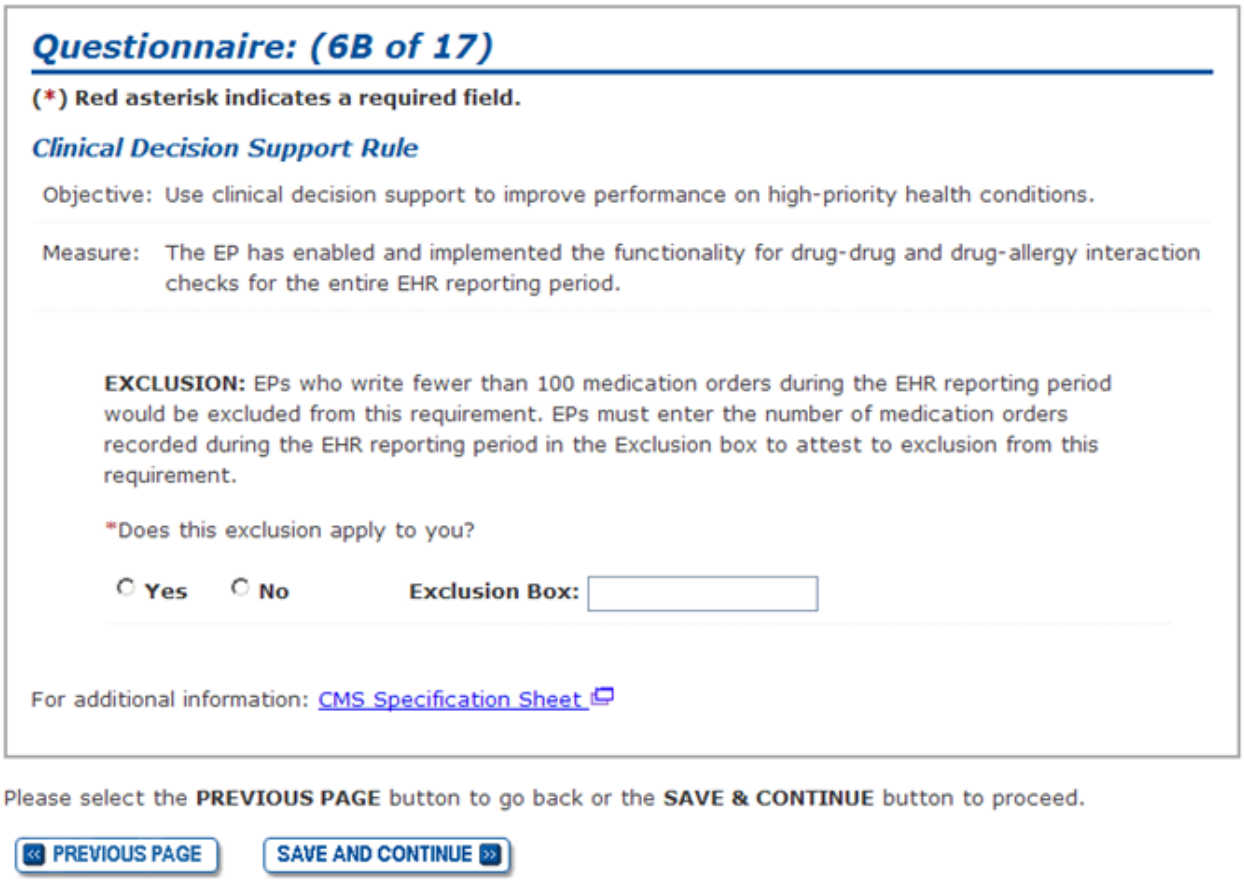


Figure 59 - MU Core Question 6B - Clinical Decision Support Rule

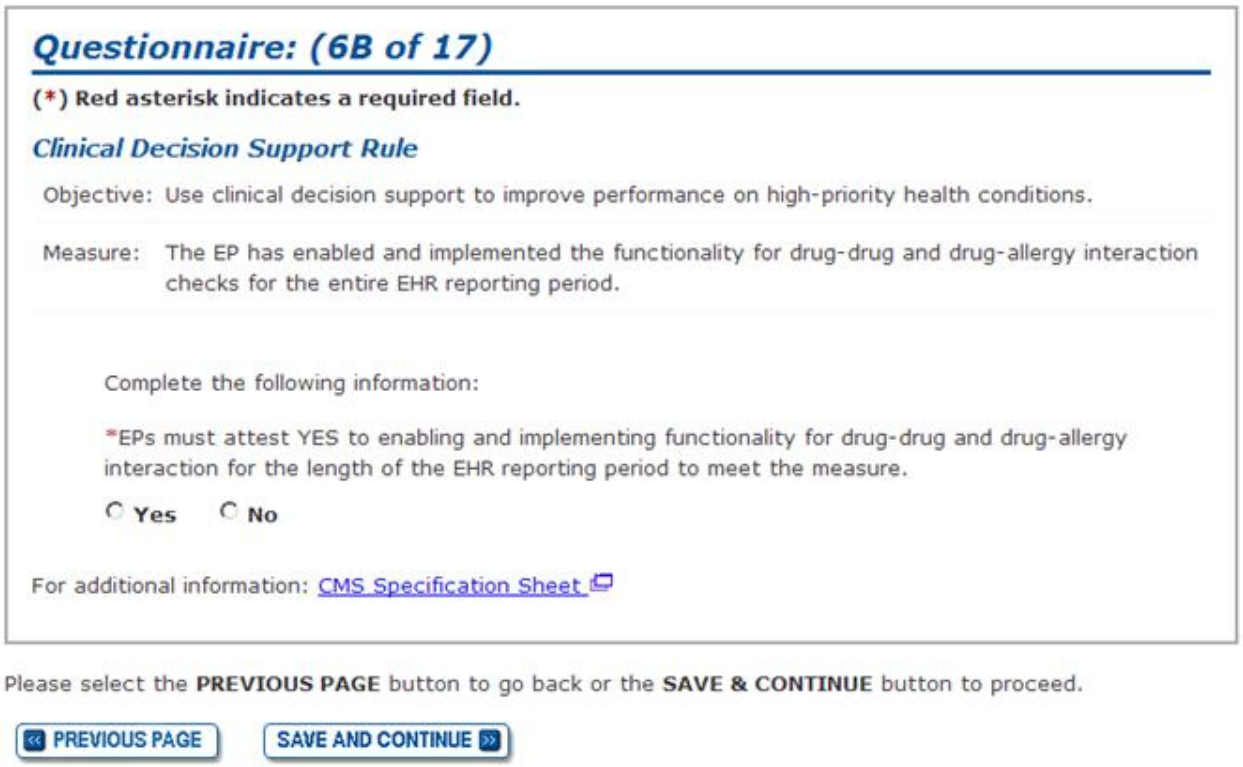


Figure 60 - MU Core Question 6B - Attest for clinical decision support rule

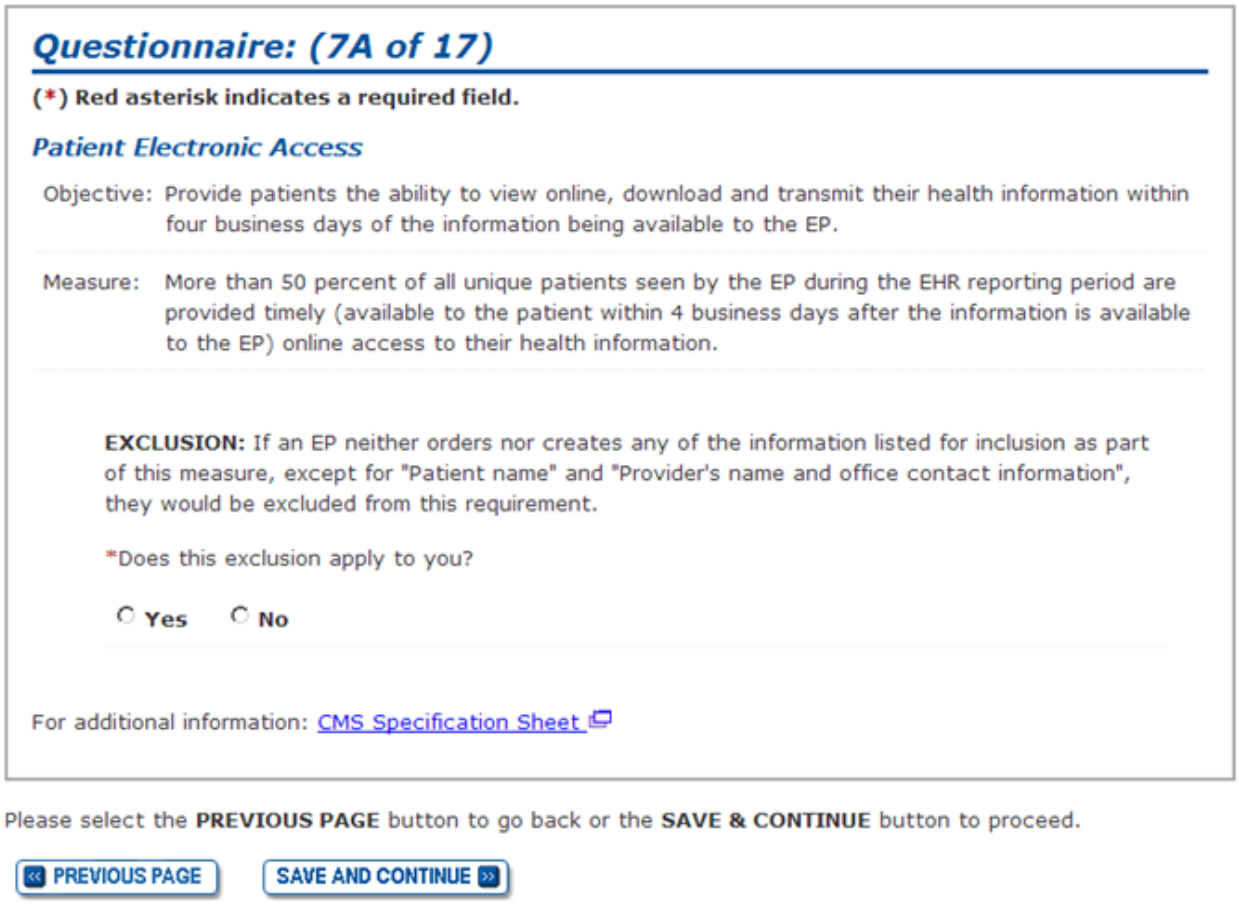


Figure 61- MU Core Question 7A – Patient Electronic Access

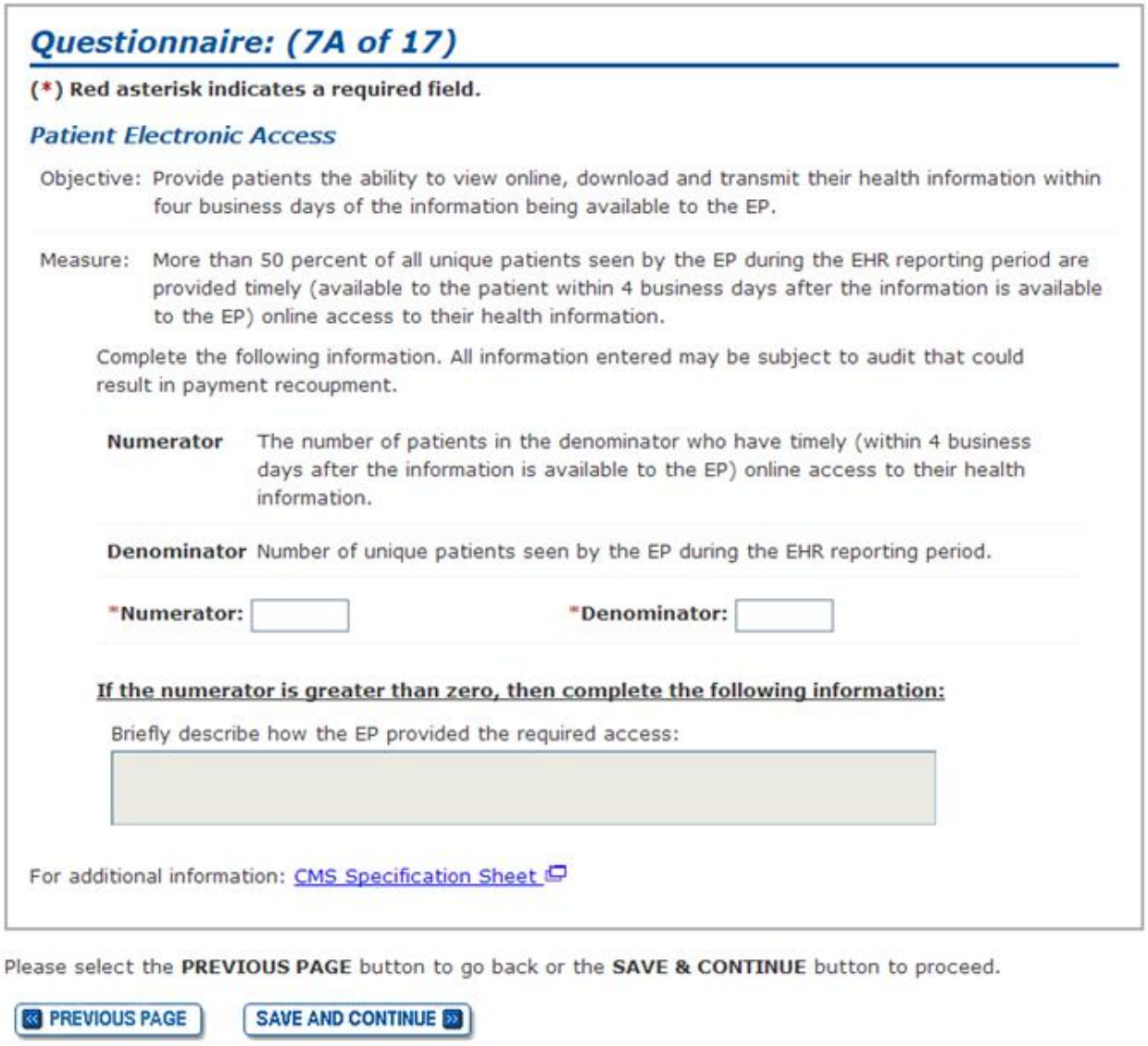


Figure 62 - MU Core Question 7A – Numerator & Denominator Entry Screen

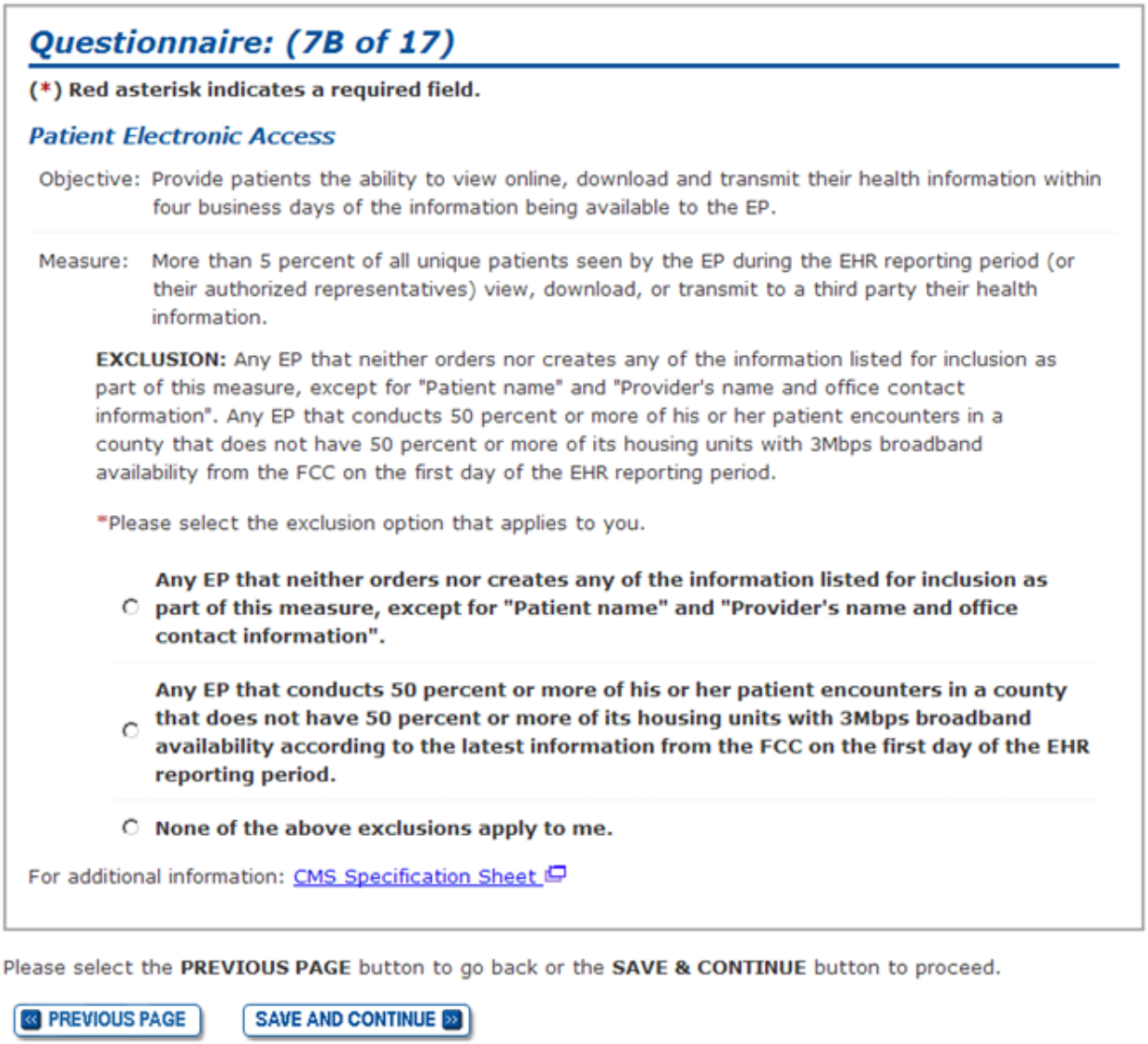


Figure 63 - MU Core Question 7B - Patient Electronic Access

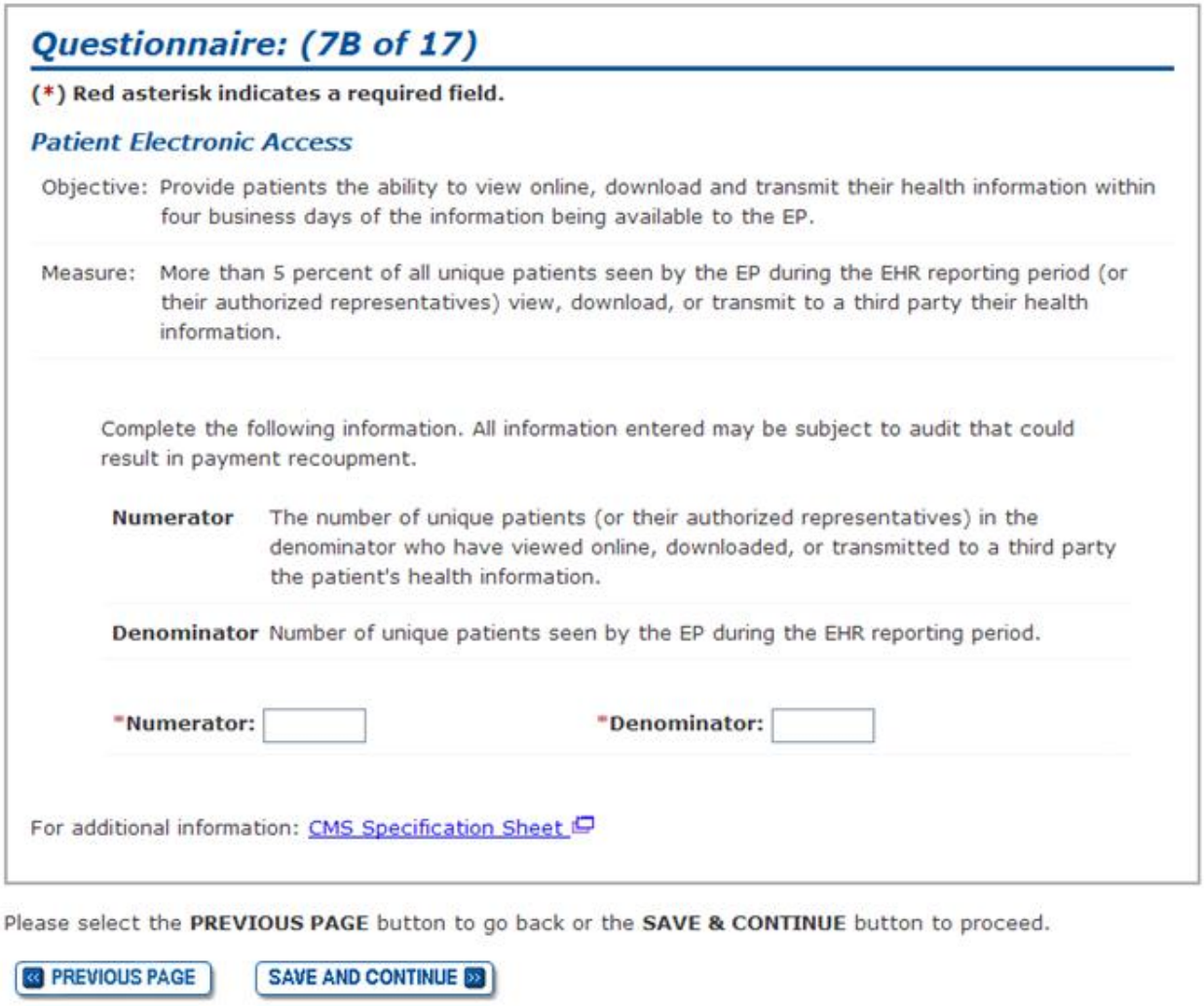


Figure 64 - MU Core Question 7B Numerator & Denominator Entry Screen

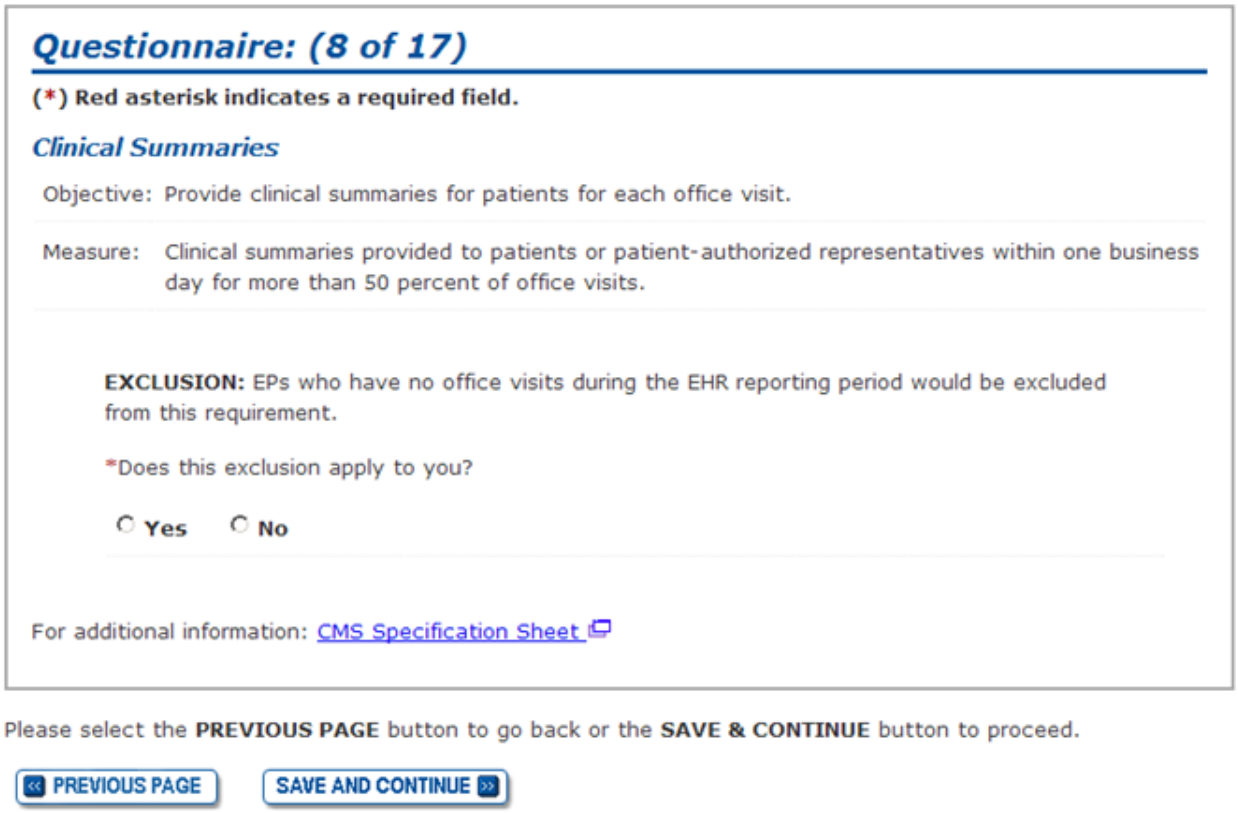


Figure 65 - MU Core Question 8 - Clinical Summaries

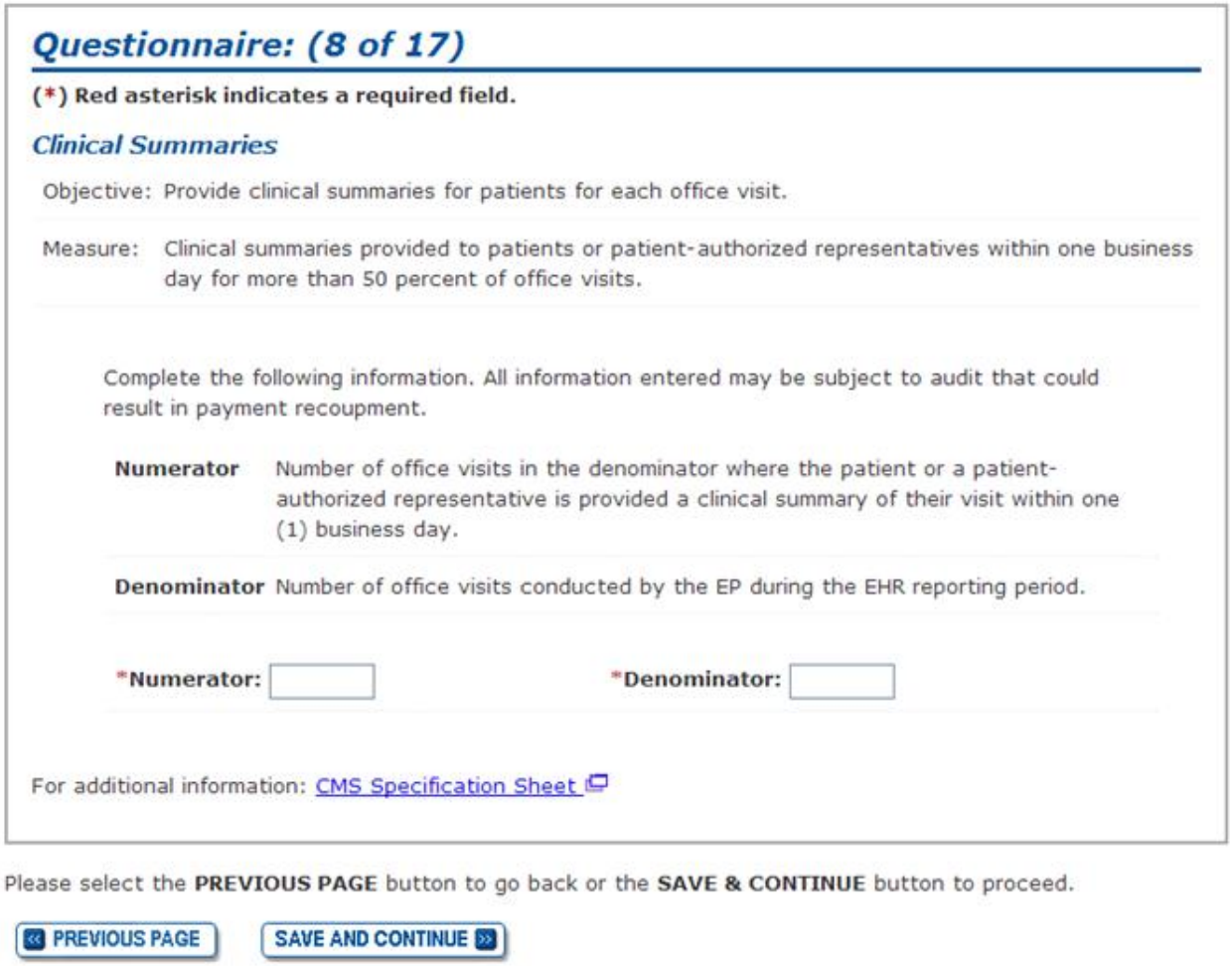


Figure 66 - MU Core Question 8 Numerator & Denominator Entry Screen

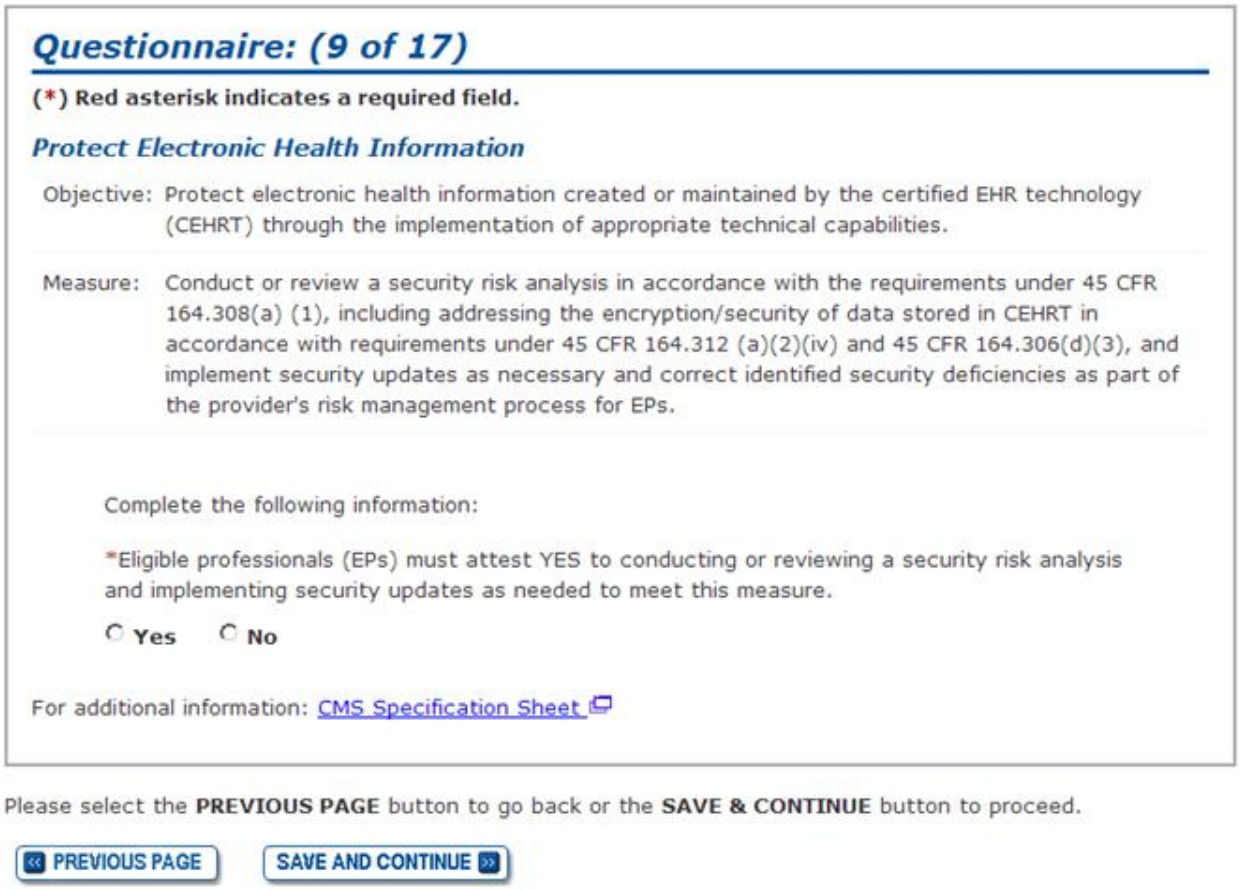


Figure 67 - MU Core Question 9 - Protect Electronic Health Information

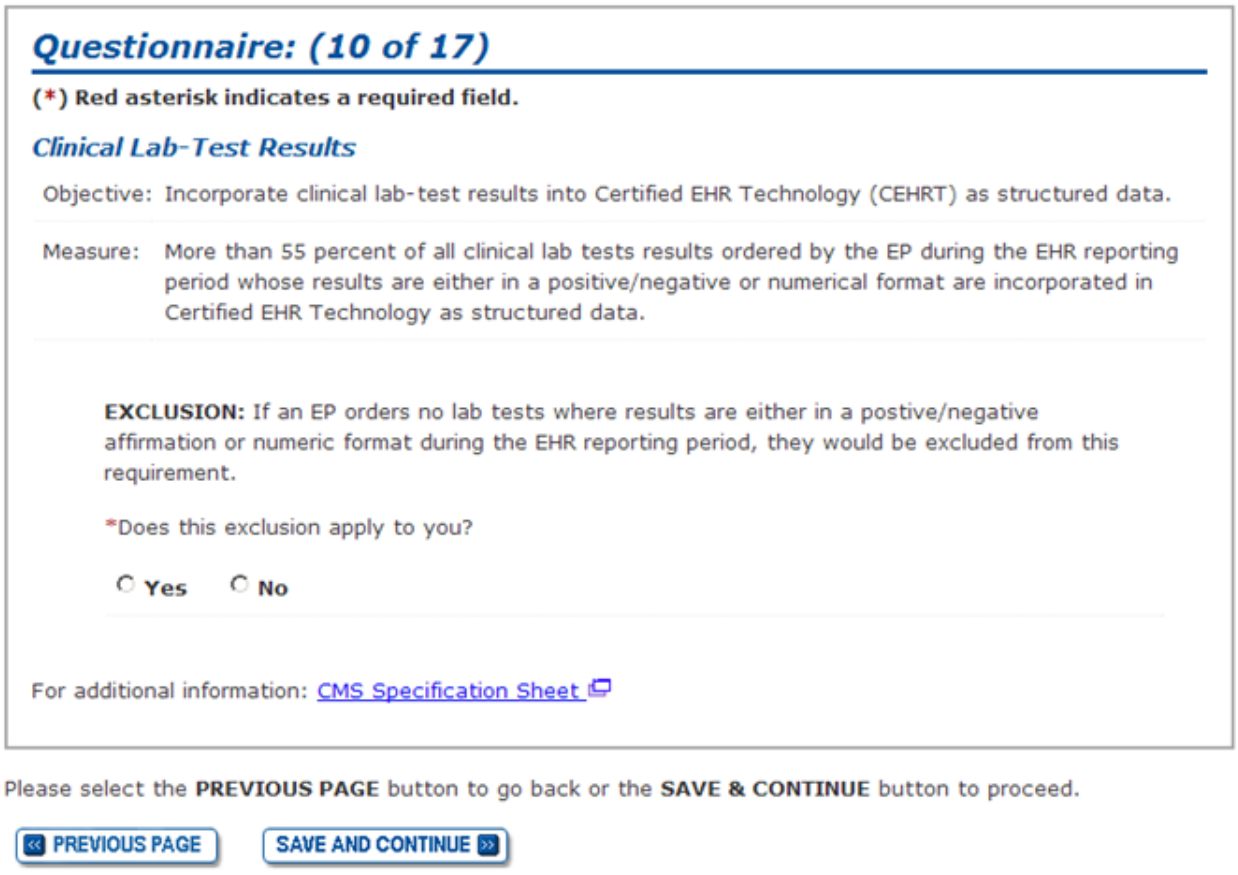


Figure 68 - MU Core Question 10 - Clinical Lab-Test Results

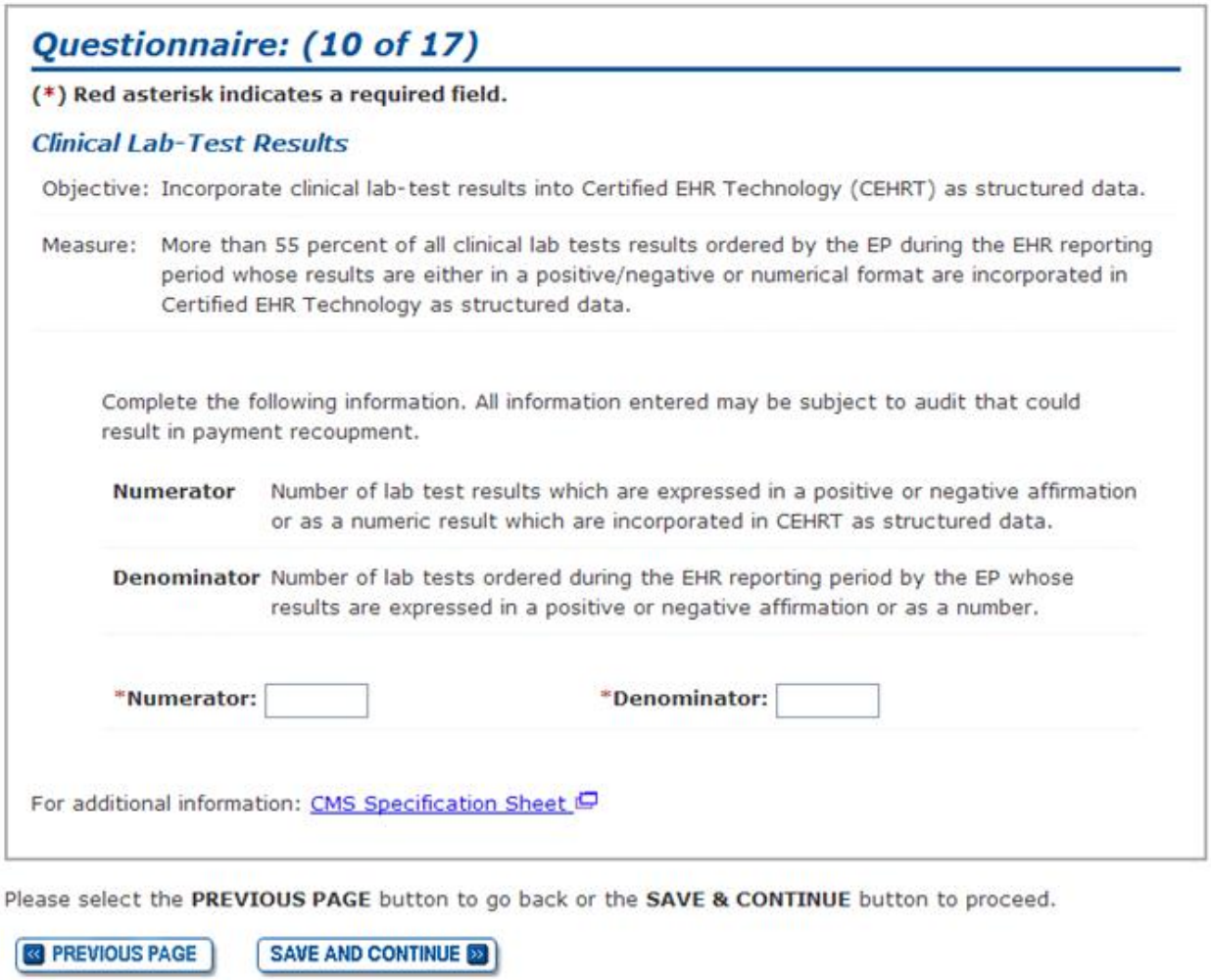


Figure 69 - MU Core Question 10 Numerator & Denominator Entry Screen

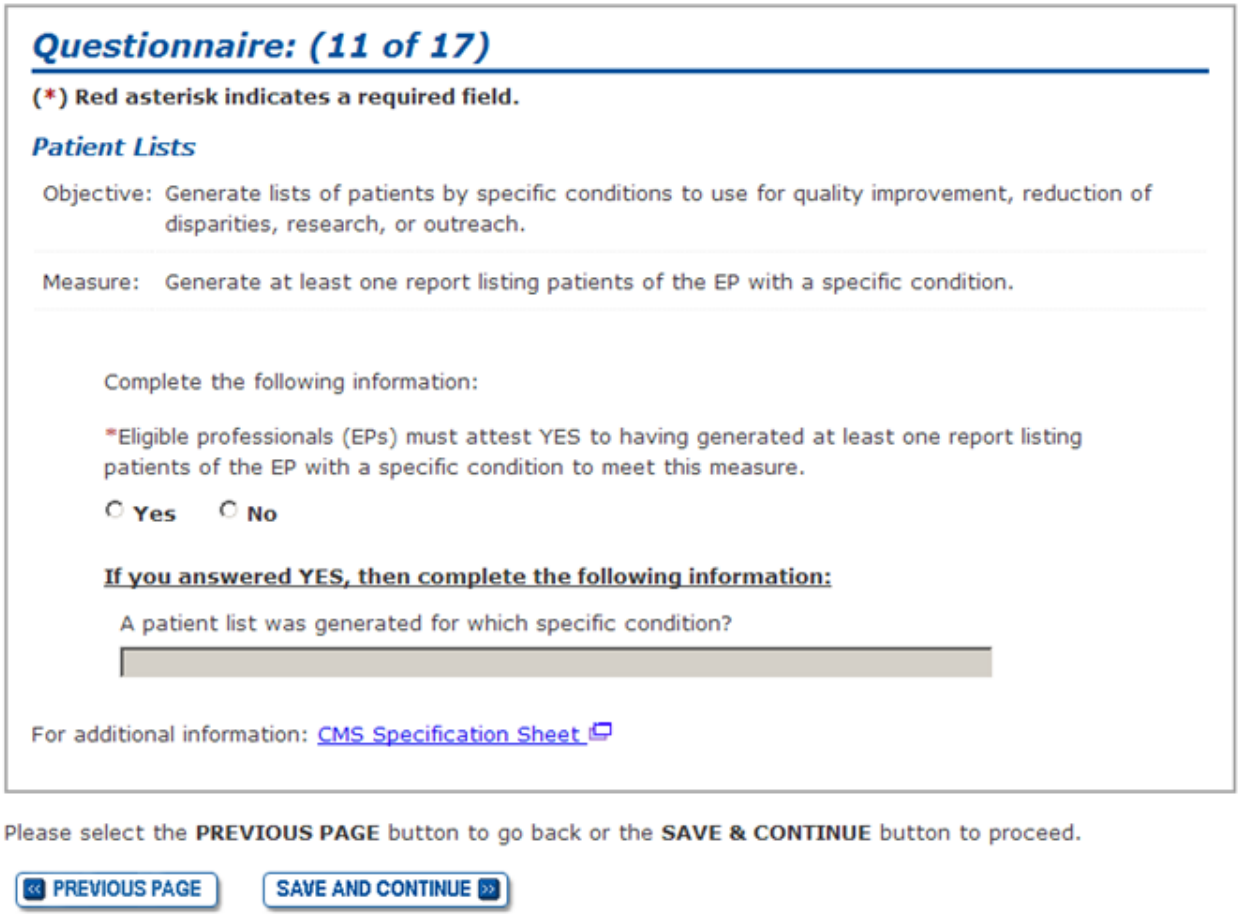


Figure 70 - MU Core Question 11 - Patient Lists

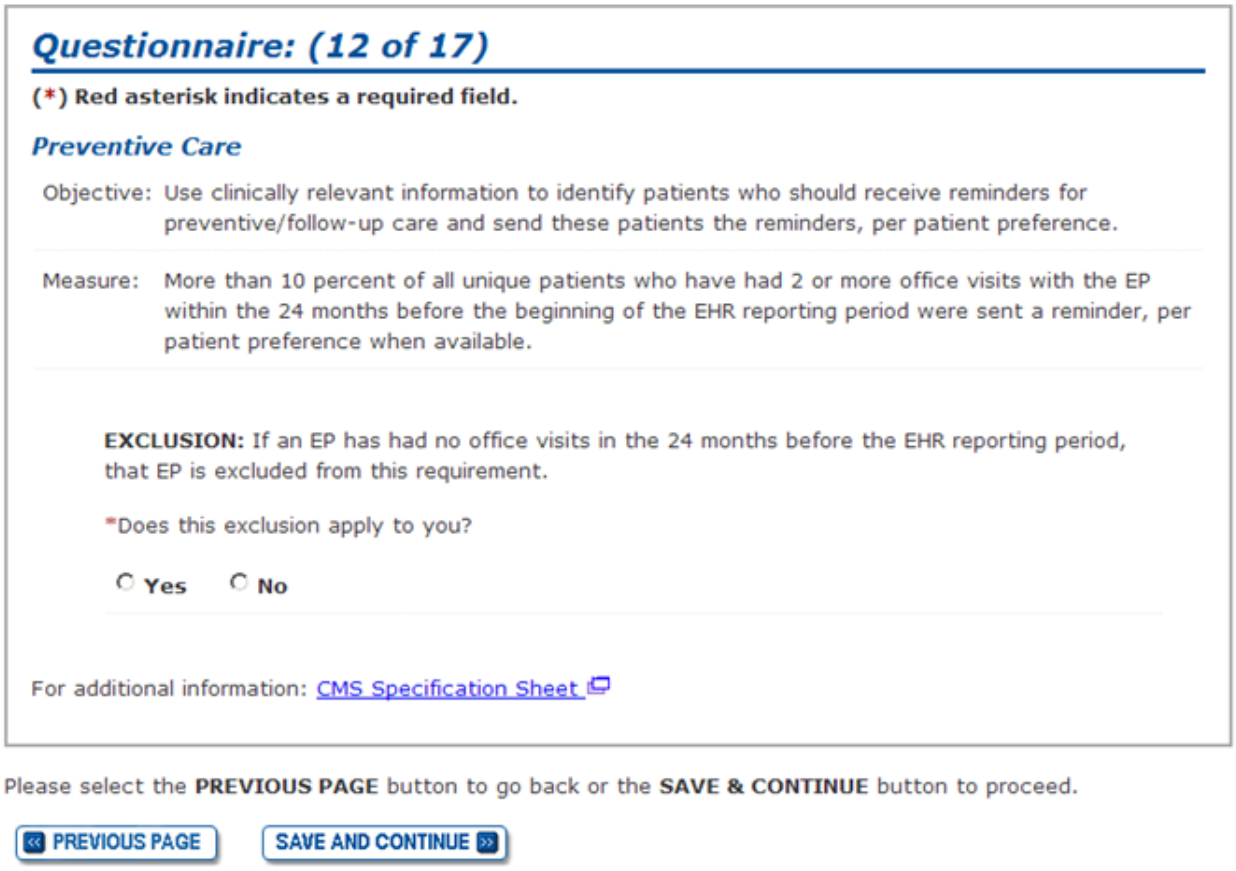


Figure 71 - MU Core Question 12 - Preventive Care

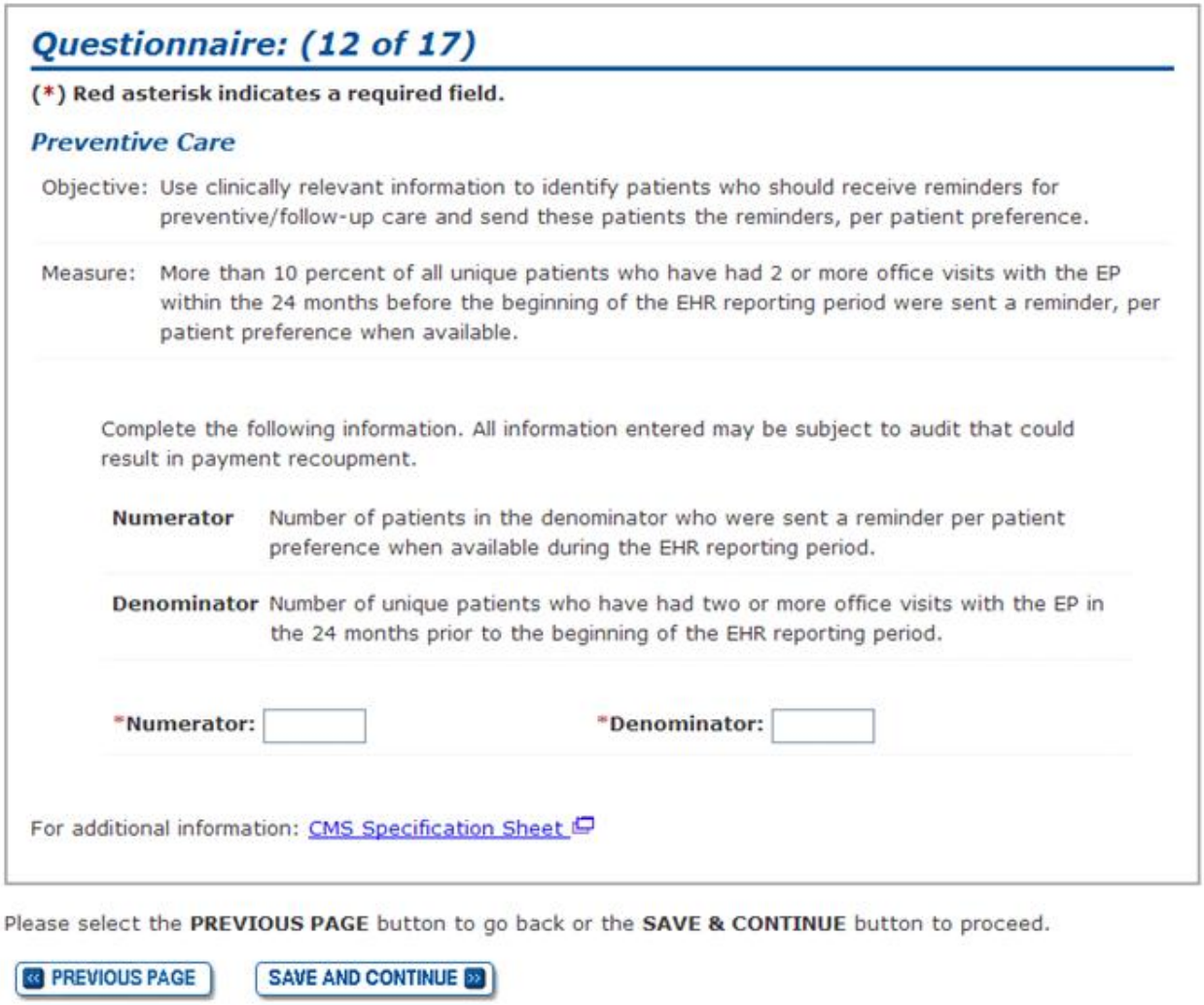


Figure 72 - MU Core Question 12 Numerator & Denominator Entry Screen

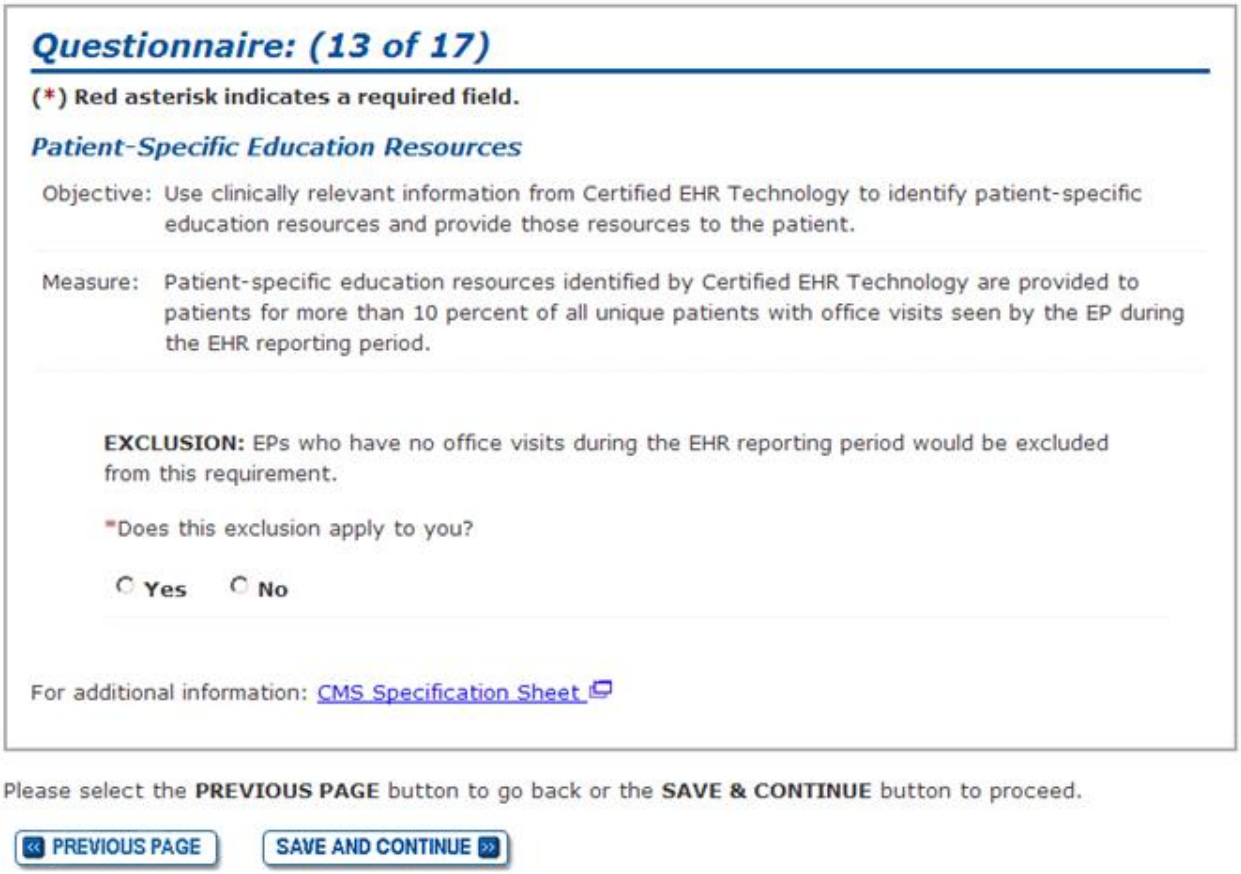


Figure 73 - MU Core Question 13 - Patient-Specific Education Resources

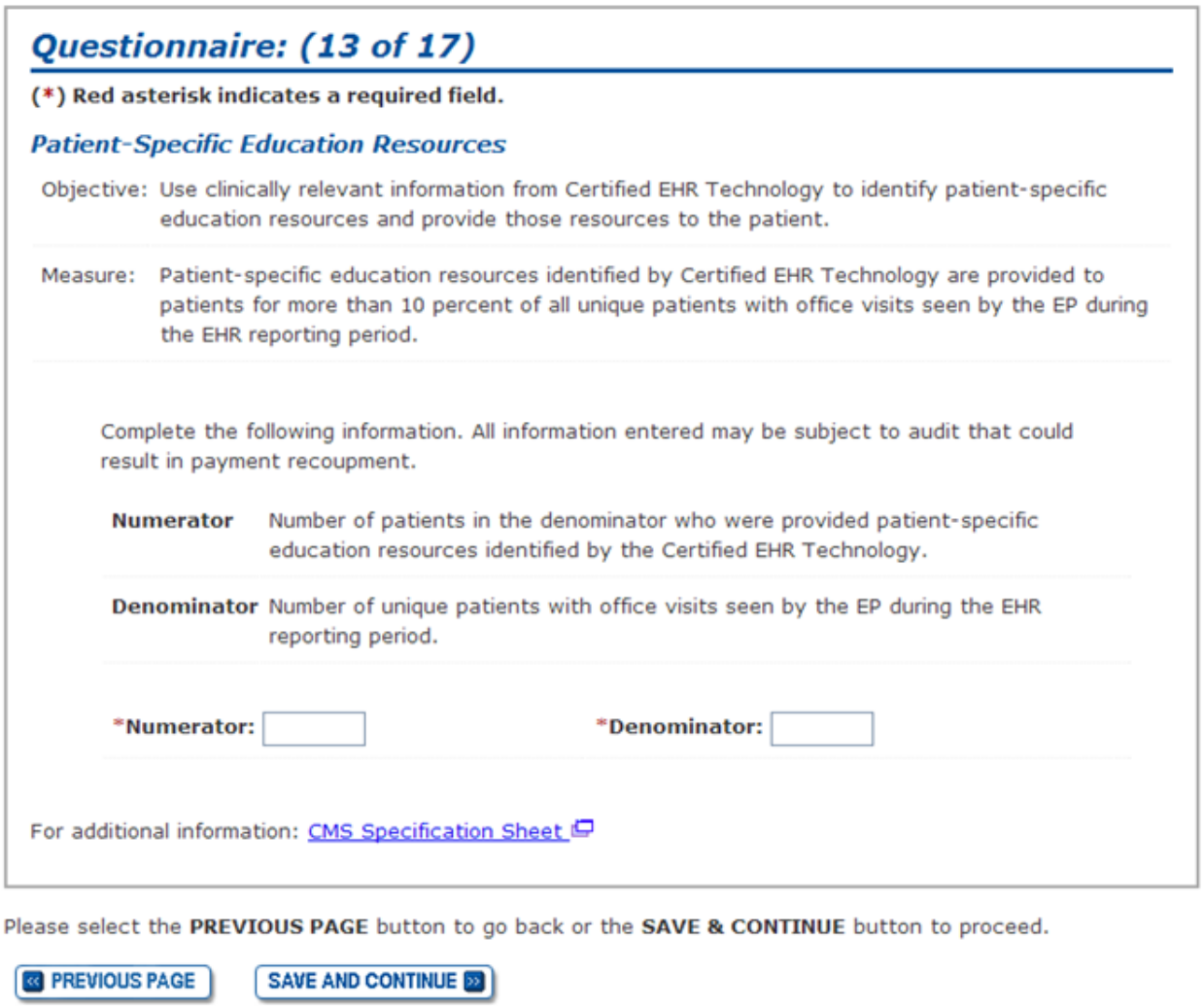


Figure 74 - MU Core Question 13 Numerator & Denominator Entry Screen

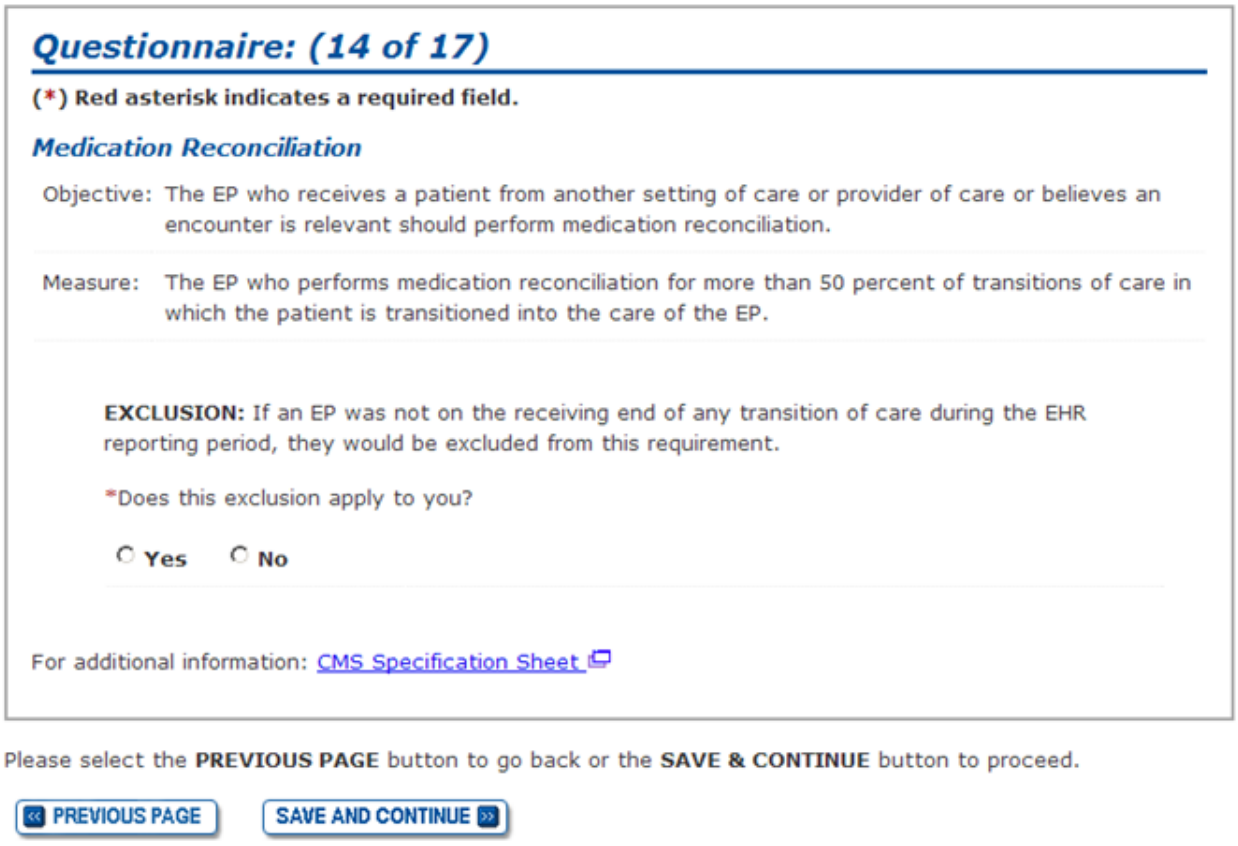


Figure 75 - MU Core Question 14 - Medication Reconciliation

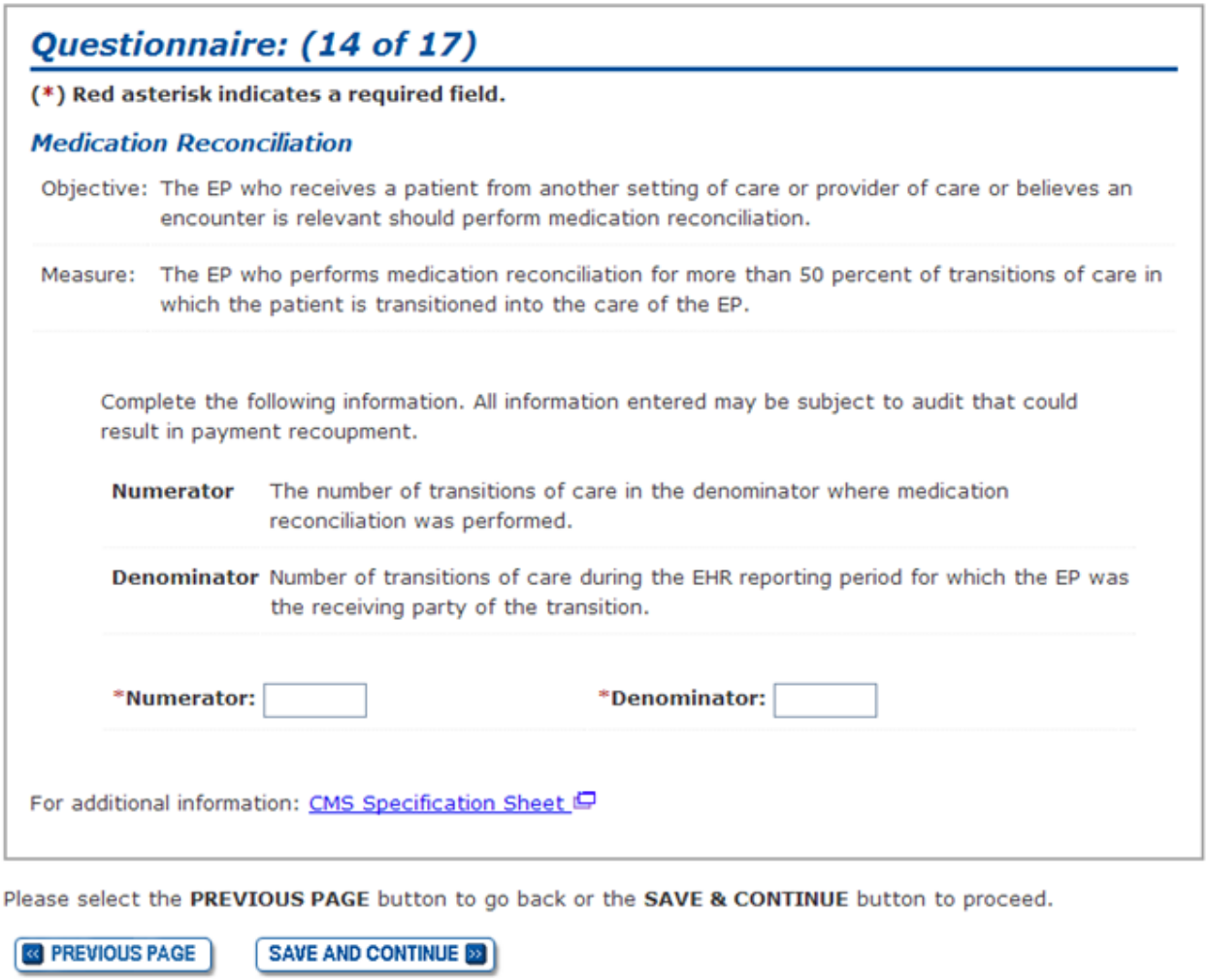


Figure 76 - MU Core Question 14 Numerator & Denominator Entry Screen

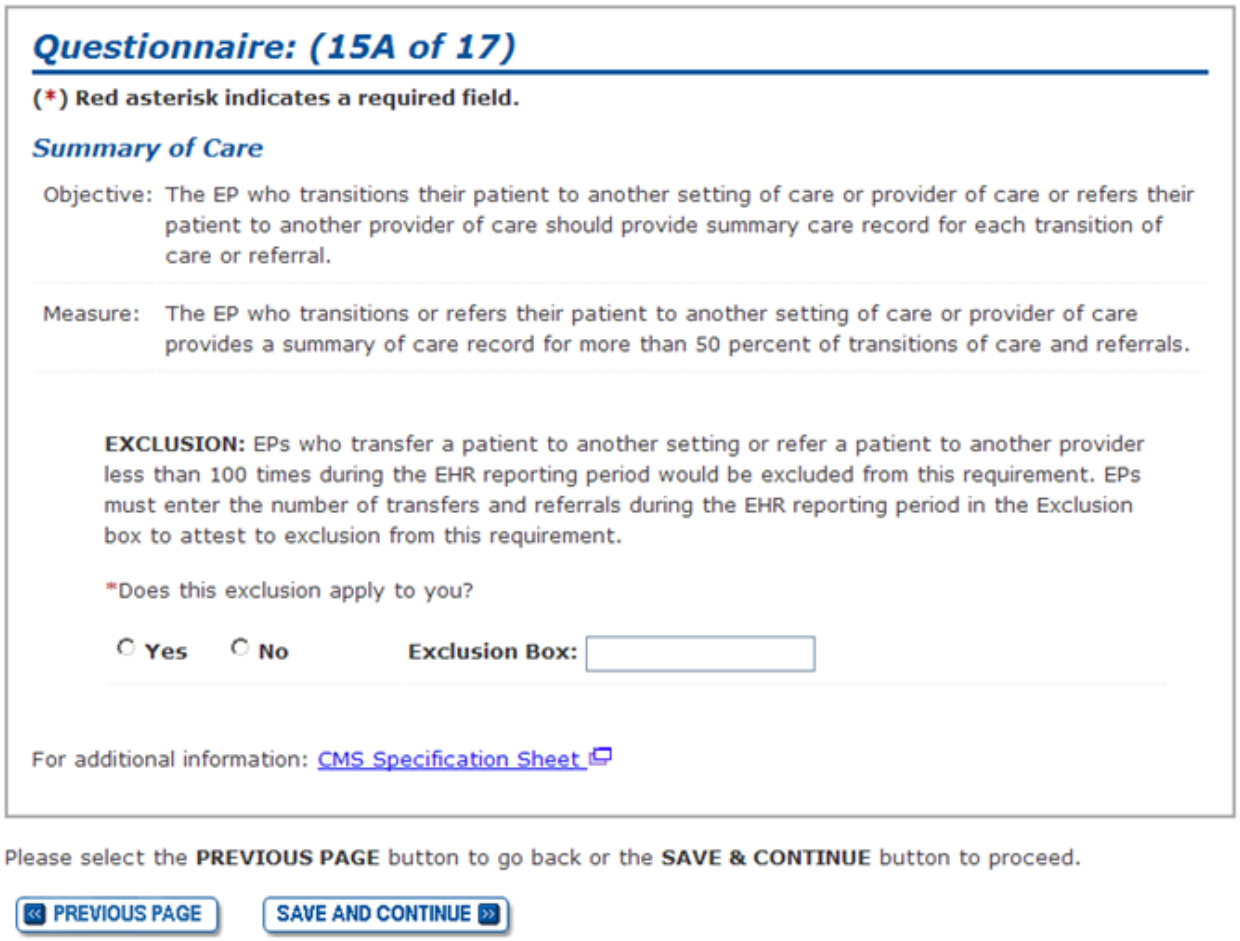


Figure 77 - MU Core Question 15A - Summary of Care

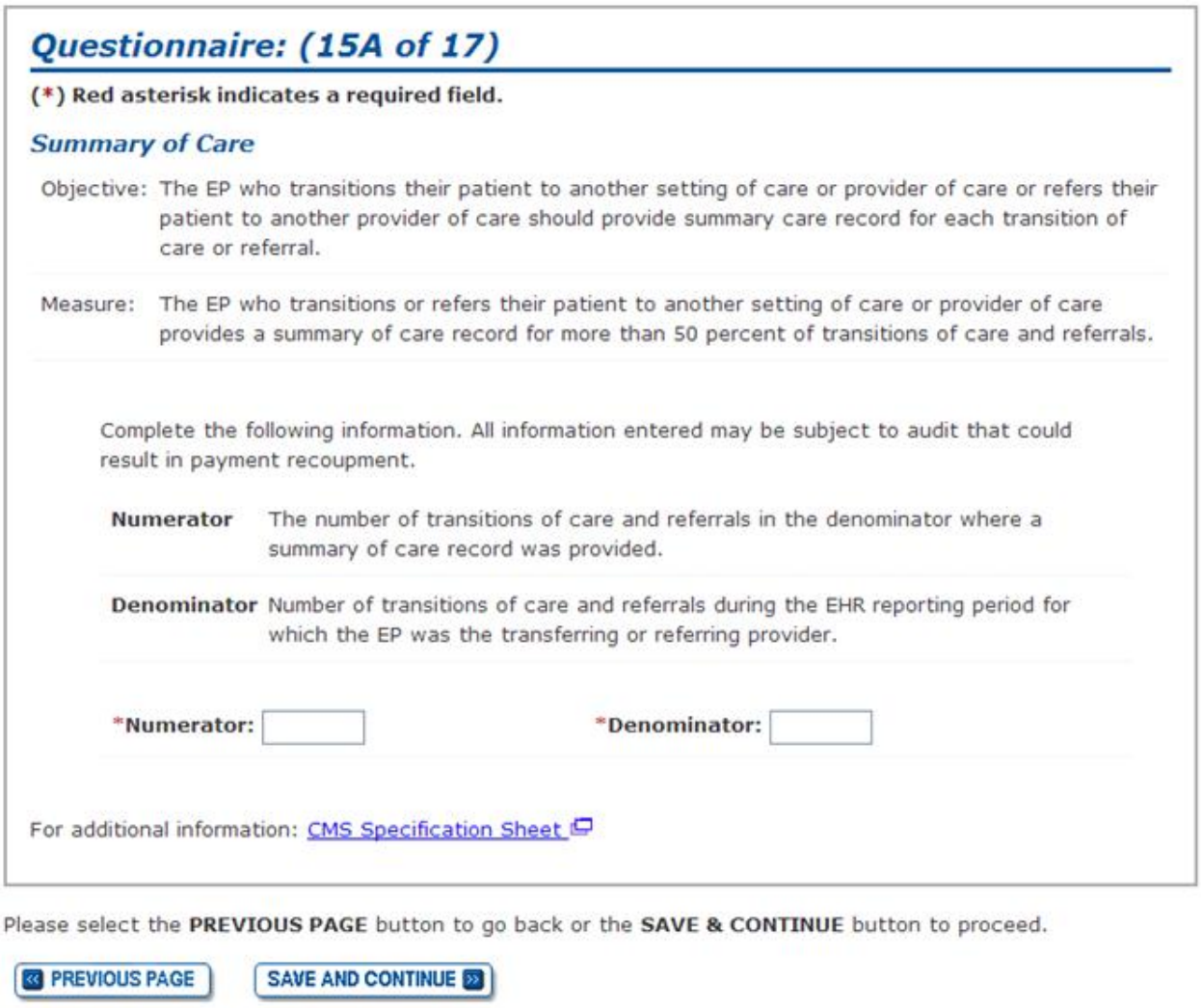


Figure 78 - MU Core Question 15A Numerator & Denominator Entry Screen

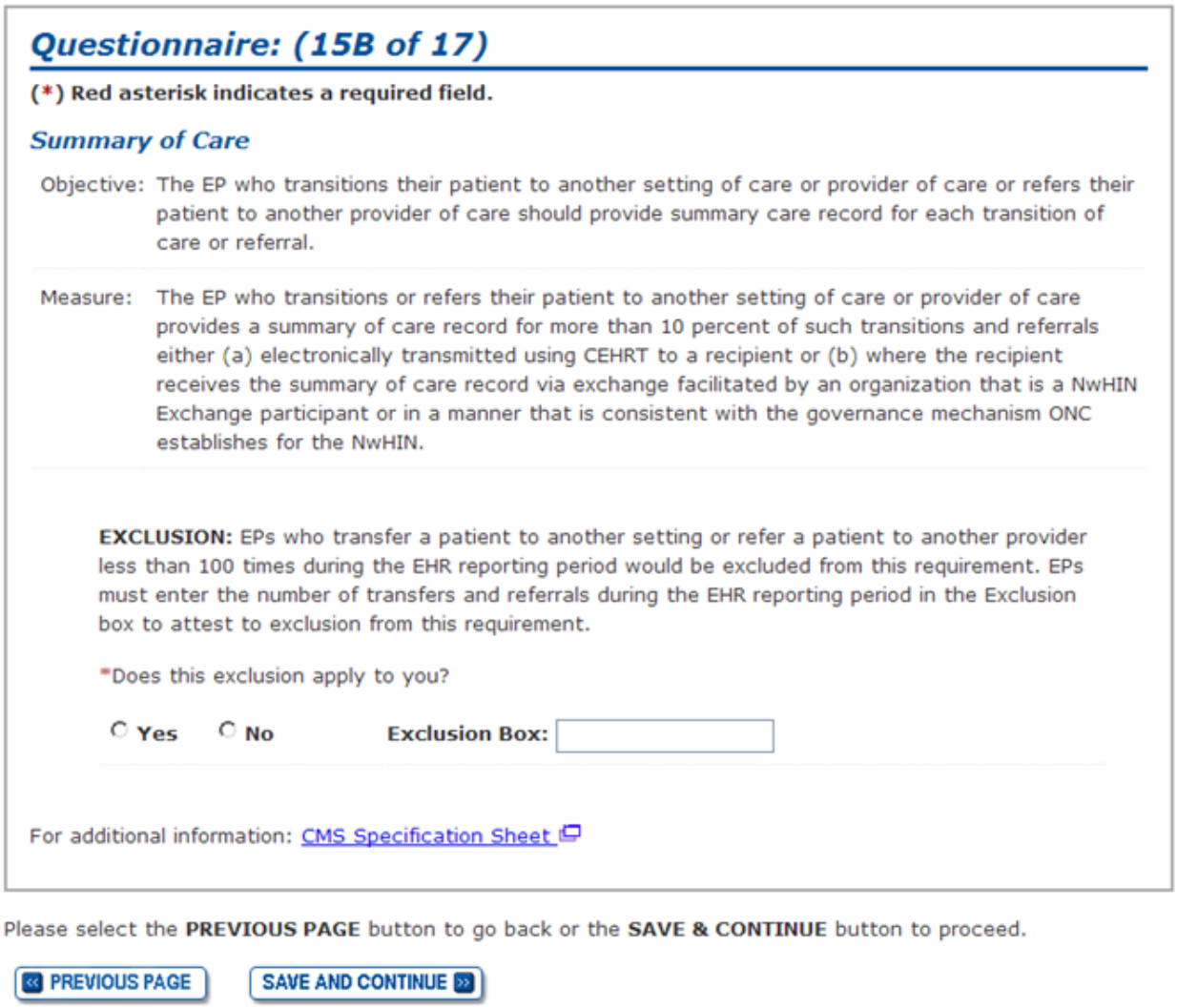


Figure 79 - MU Core Question 15B - Summary of Care

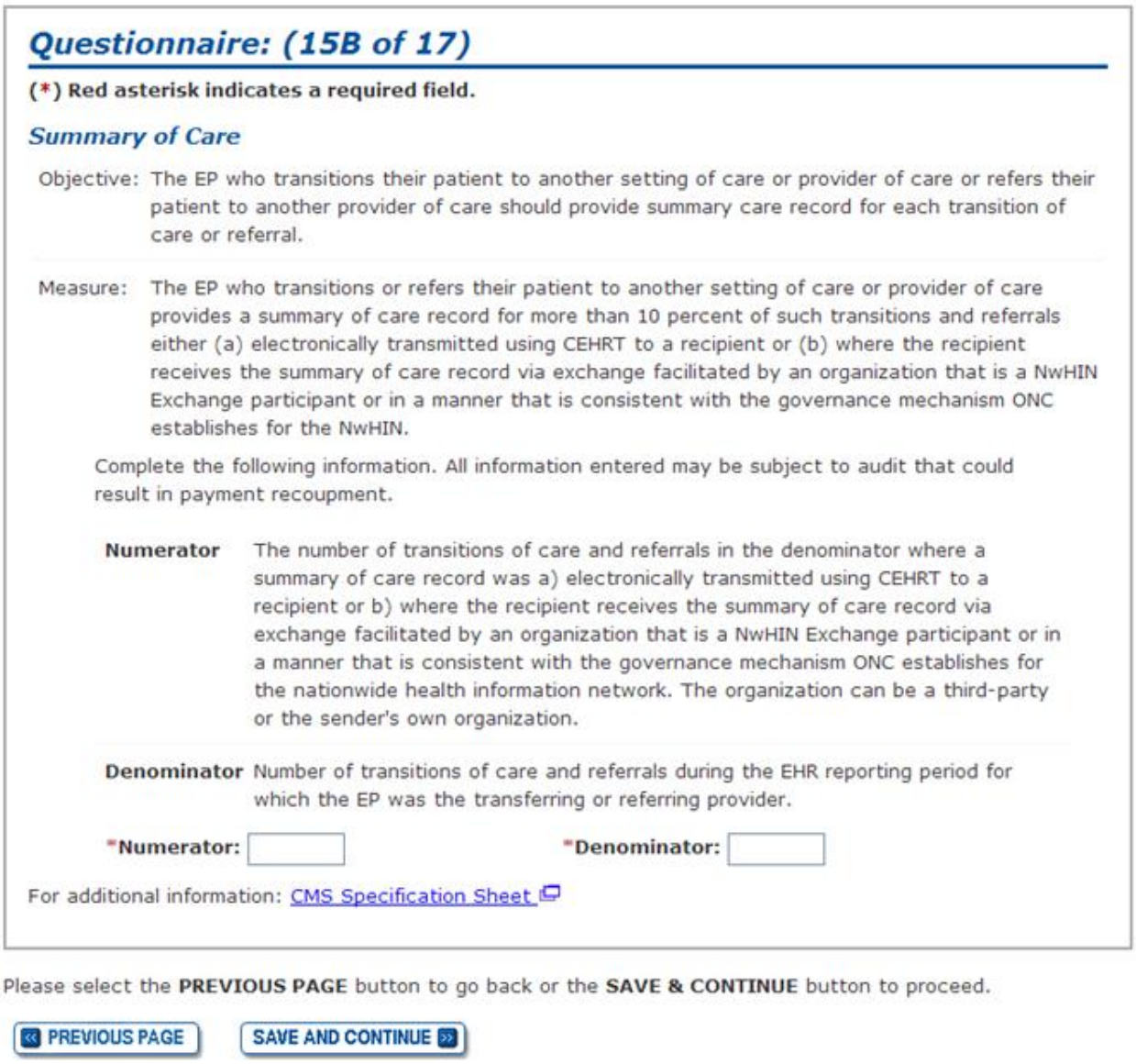


Figure 80 - MU Core Question 15B Numerator & Denominator Entry Screen

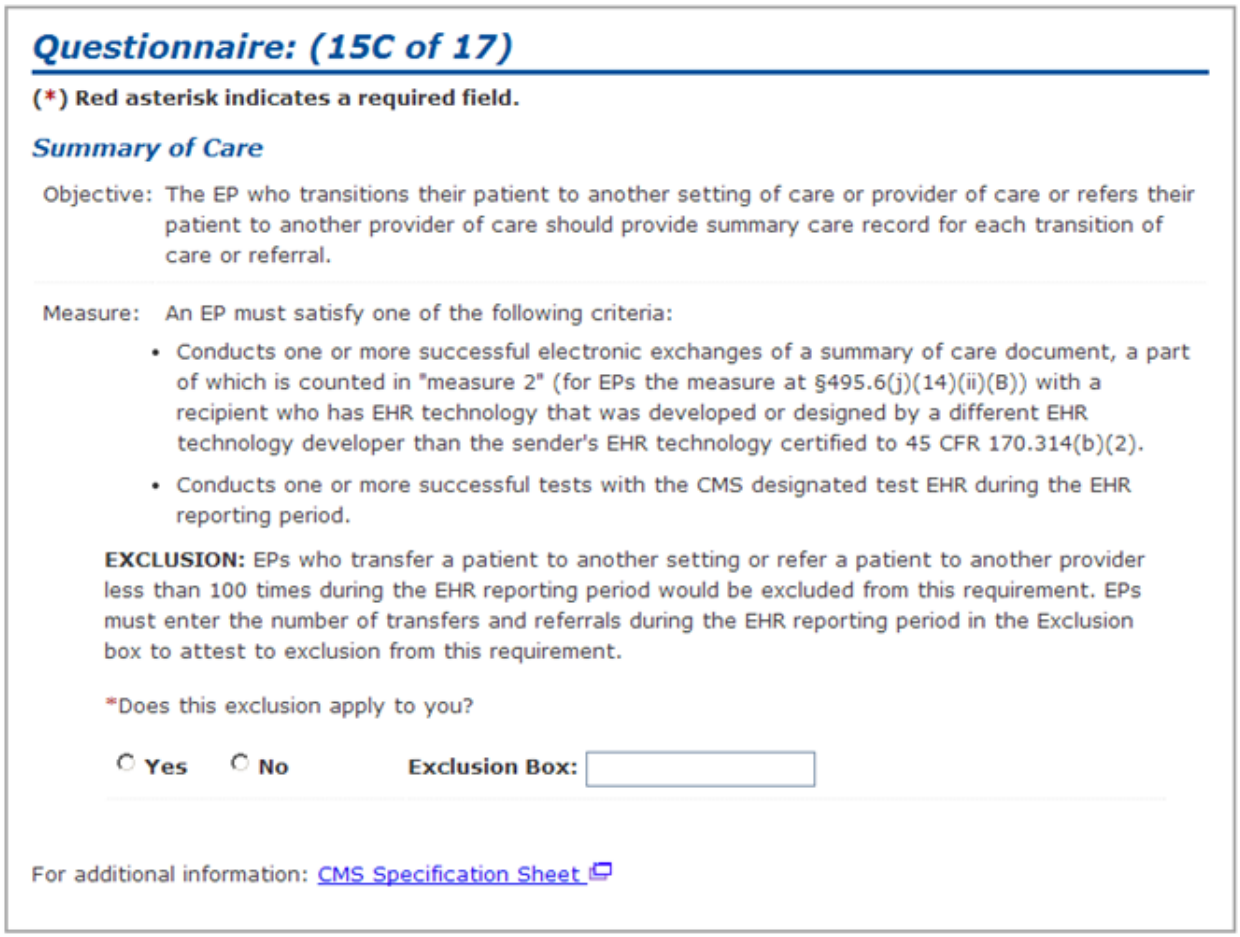
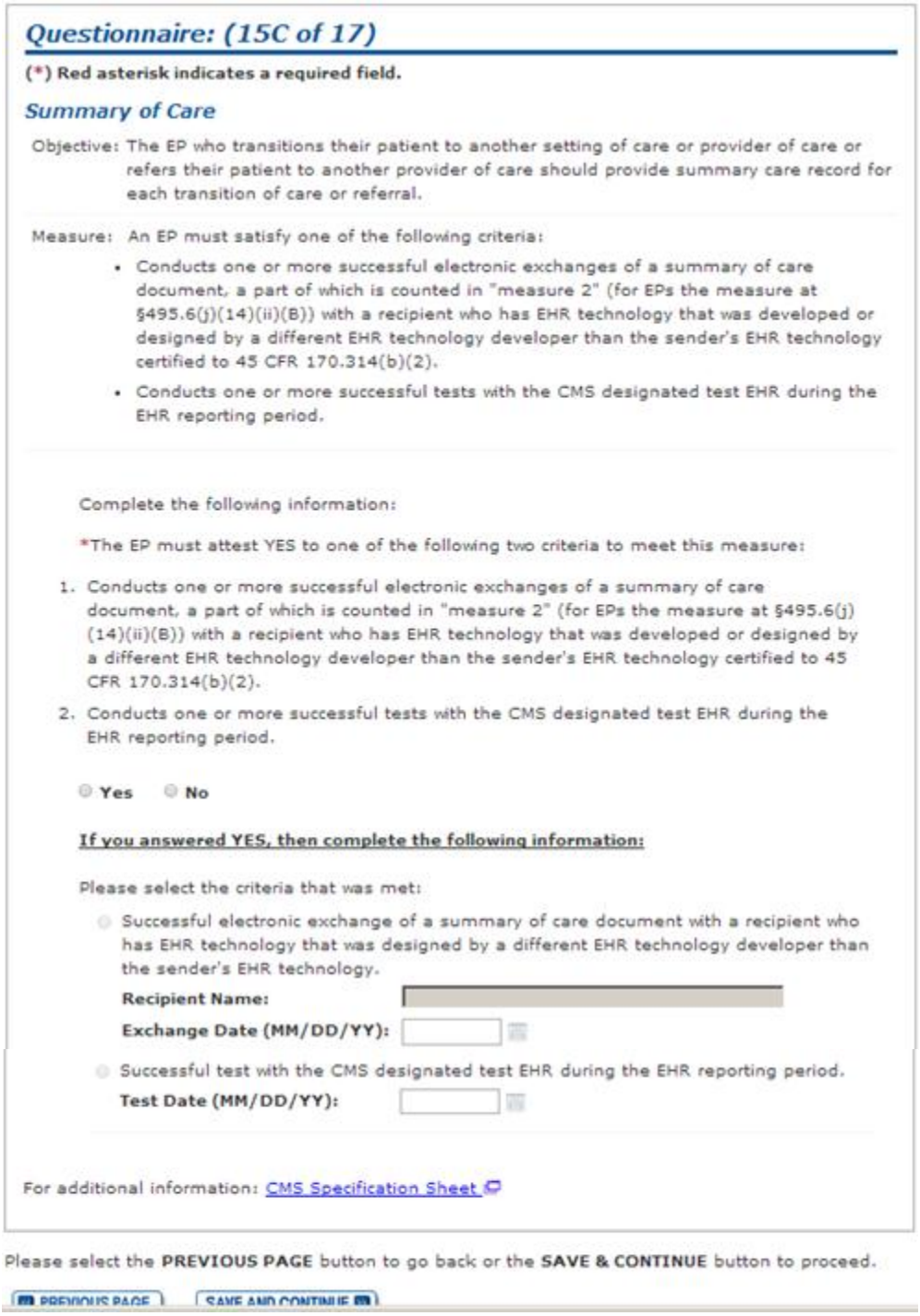


Figure 81 - MU Core Question 15C - Summary of Care



Questionnaire: (15C of 17)

(*) Red asterisk indicates a required field.

Summary of Care

Objective: The EP who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary care record for each transition of care or referral.

Measure: An EP must satisfy one of the following criteria:

- Conducts one or more successful electronic exchanges of a summary of care document, a part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B)) with a recipient who has EHR technology that was developed or designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).
- Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Complete the following information:

*The EP must attest YES to one of the following two criteria to meet this measure:

1. Conducts one or more successful electronic exchanges of a summary of care document, a part of which is counted in "measure 2" (for EPs the measure at §495.6(j)(14)(ii)(B)) with a recipient who has EHR technology that was developed or designed by a different EHR technology developer than the sender's EHR technology certified to 45 CFR 170.314(b)(2).
2. Conducts one or more successful tests with the CMS designated test EHR during the EHR reporting period.

Yes **No**

If you answered YES, then complete the following information:

Please select the criteria that was met:

Successful electronic exchange of a summary of care document with a recipient who has EHR technology that was designed by a different EHR technology developer than the sender's EHR technology.

Recipient Name:

Exchange Date (MM/DD/YY):

Successful test with the CMS designated test EHR during the EHR reporting period.

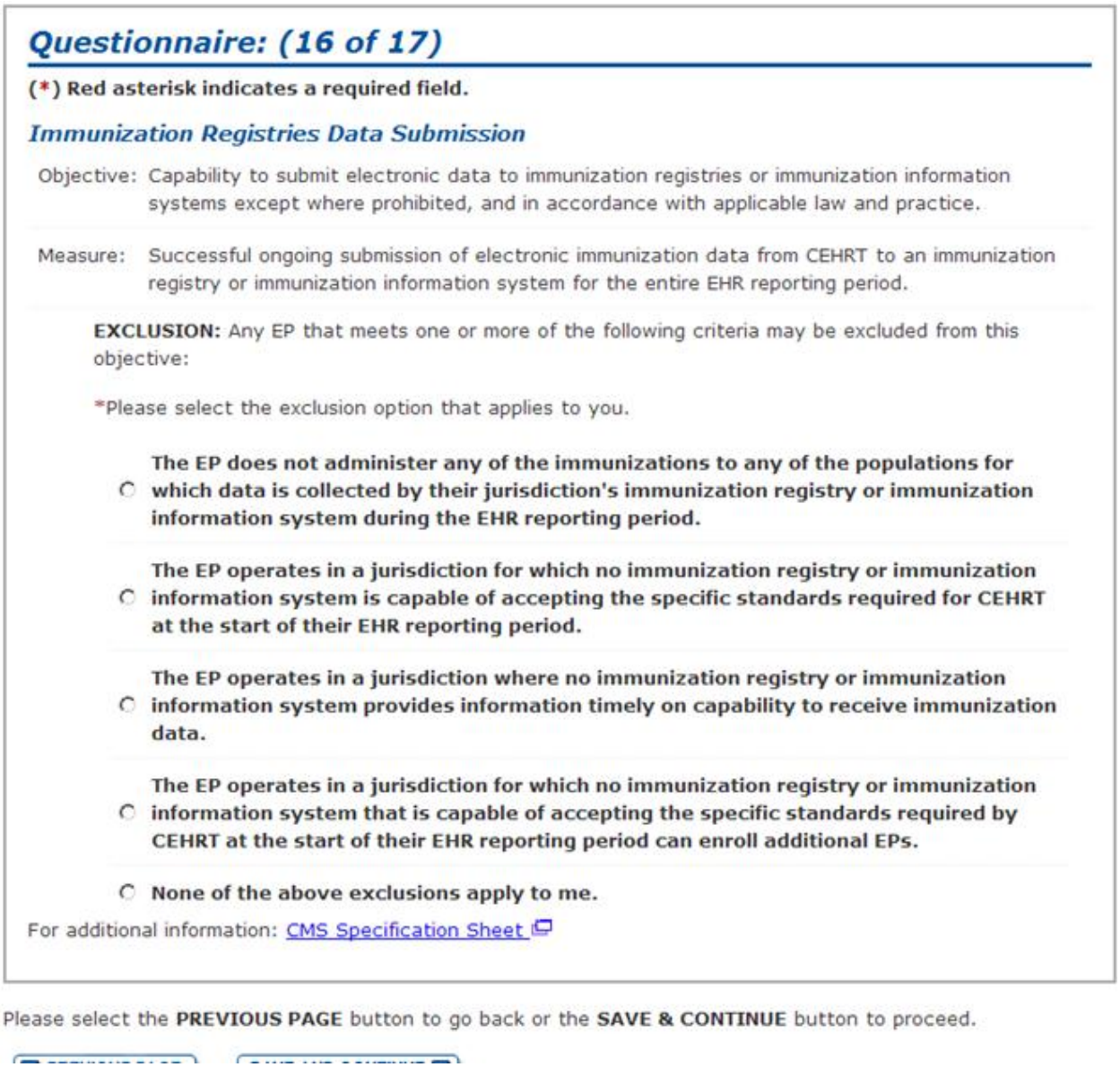
Test Date (MM/DD/YY):

For additional information: CMS Specification Sheet

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE

Figure 82 - MU Core Question 15C Additional Information Entry Screen



Questionnaire: (16 of 17)

(*) Red asterisk indicates a required field.

Immunization Registries Data Submission

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

EXCLUSION: Any EP that meets one or more of the following criteria may be excluded from this objective:

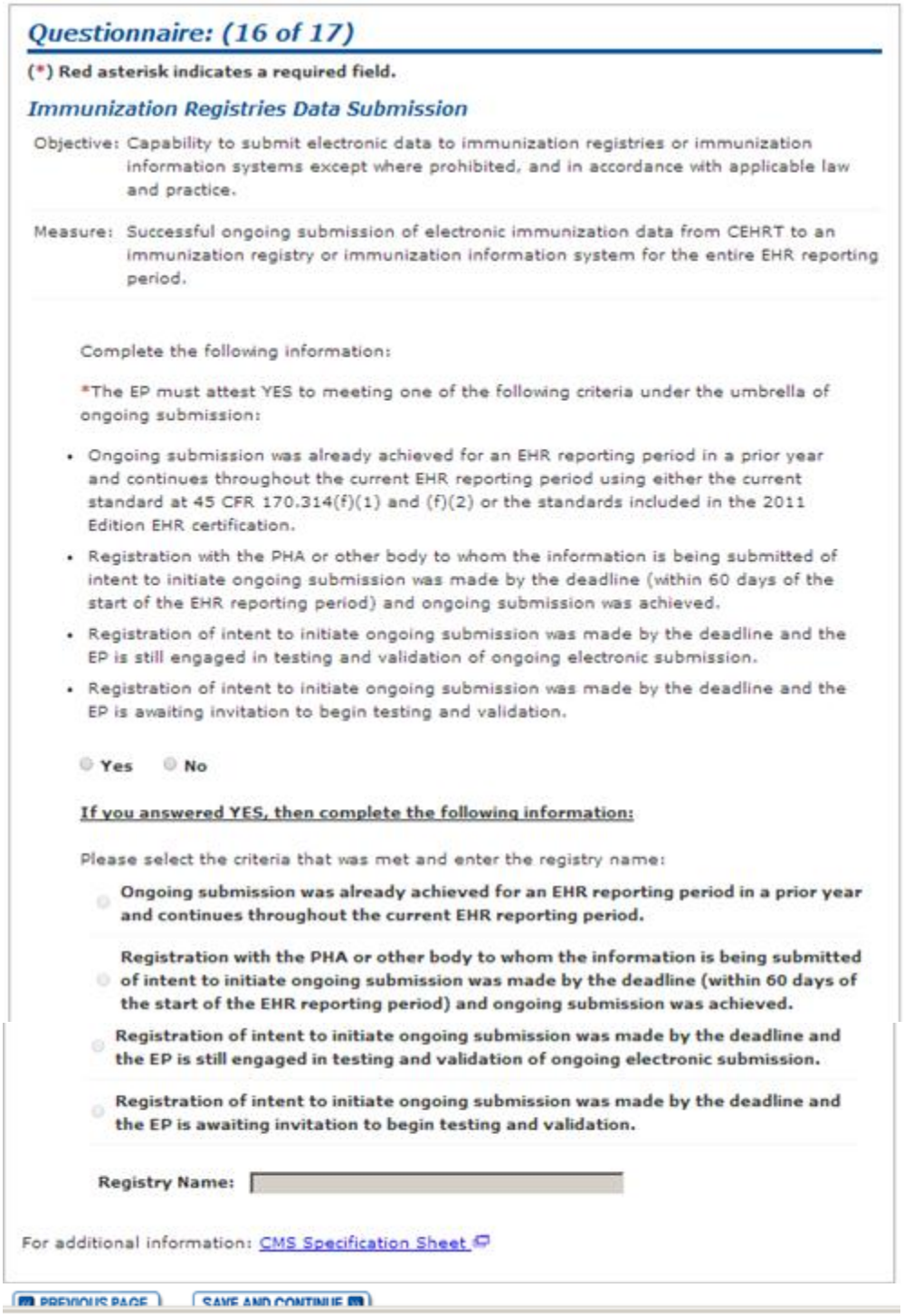
*Please select the exclusion option that applies to you.

- ○ **The EP does not administer any of the immunizations to any of the populations for which data is collected by their jurisdiction's immunization registry or immunization information system during the EHR reporting period.**
- ○ **The EP operates in a jurisdiction for which no immunization registry or immunization information system is capable of accepting the specific standards required for CEHRT at the start of their EHR reporting period.**
- ○ **The EP operates in a jurisdiction where no immunization registry or immunization information system provides information timely on capability to receive immunization data.**
- ○ **The EP operates in a jurisdiction for which no immunization registry or immunization information system that is capable of accepting the specific standards required by CEHRT at the start of their EHR reporting period can enroll additional EPs.**
- ○ **None of the above exclusions apply to me.**

For additional information: CMS Specification Sheet

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

Figure 83 - MU Core Question 16 - Immunization Registries Data Submission



Questionnaire: (16 of 17)

(*) Red asterisk indicates a required field.

Immunization Registries Data Submission

Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice.

Measure: Successful ongoing submission of electronic immunization data from CEHRT to an immunization registry or immunization information system for the entire EHR reporting period.

Complete the following information:

*The EP must attest YES to meeting one of the following criteria under the umbrella of ongoing submission:

- Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period using either the current standard at 45 CFR 170.314(f)(1) and (f)(2) or the standards included in the 2011 Edition EHR certification.
- Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP is still engaged in testing and validation of ongoing electronic submission.
- Registration of intent to initiate ongoing submission was made by the deadline and the EP is awaiting invitation to begin testing and validation.

Yes No

If you answered YES, then complete the following information:

Please select the criteria that was met and enter the registry name:

Ongoing submission was already achieved for an EHR reporting period in a prior year and continues throughout the current EHR reporting period.

Registration with the PHA or other body to whom the information is being submitted of intent to initiate ongoing submission was made by the deadline (within 60 days of the start of the EHR reporting period) and ongoing submission was achieved.

Registration of intent to initiate ongoing submission was made by the deadline and the EP is still engaged in testing and validation of ongoing electronic submission.

Registration of intent to initiate ongoing submission was made by the deadline and the EP is awaiting invitation to begin testing and validation.

Registry Name:

For additional information: CMS Specification Sheet

PREVIOUS PAGE SAVE AND CONTINUE

Figure 84 - MU Core Question 16 Additional Information Entry Screen

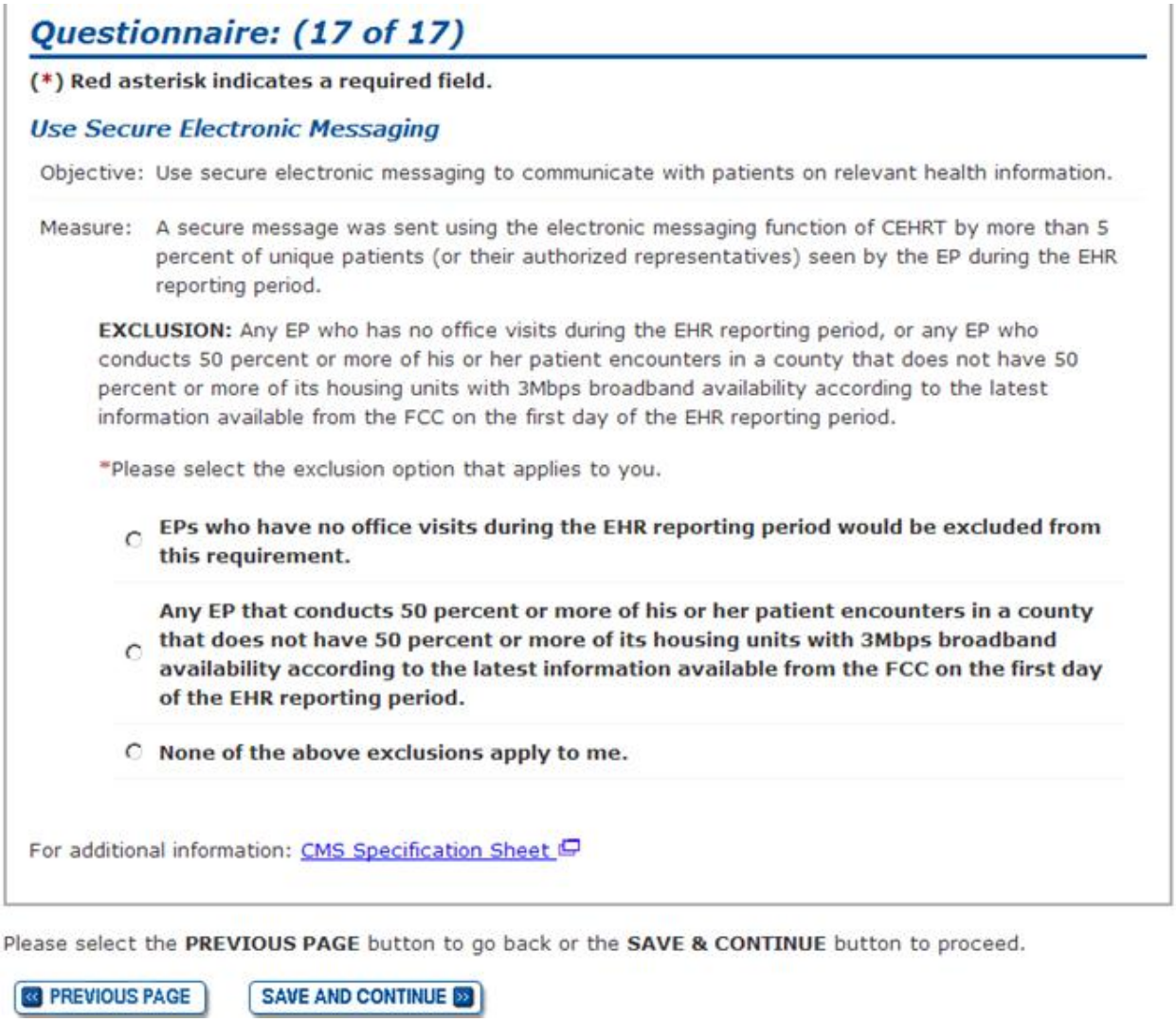


Figure 85 – MU Core Question 17 - Use Secure Electronic Messaging

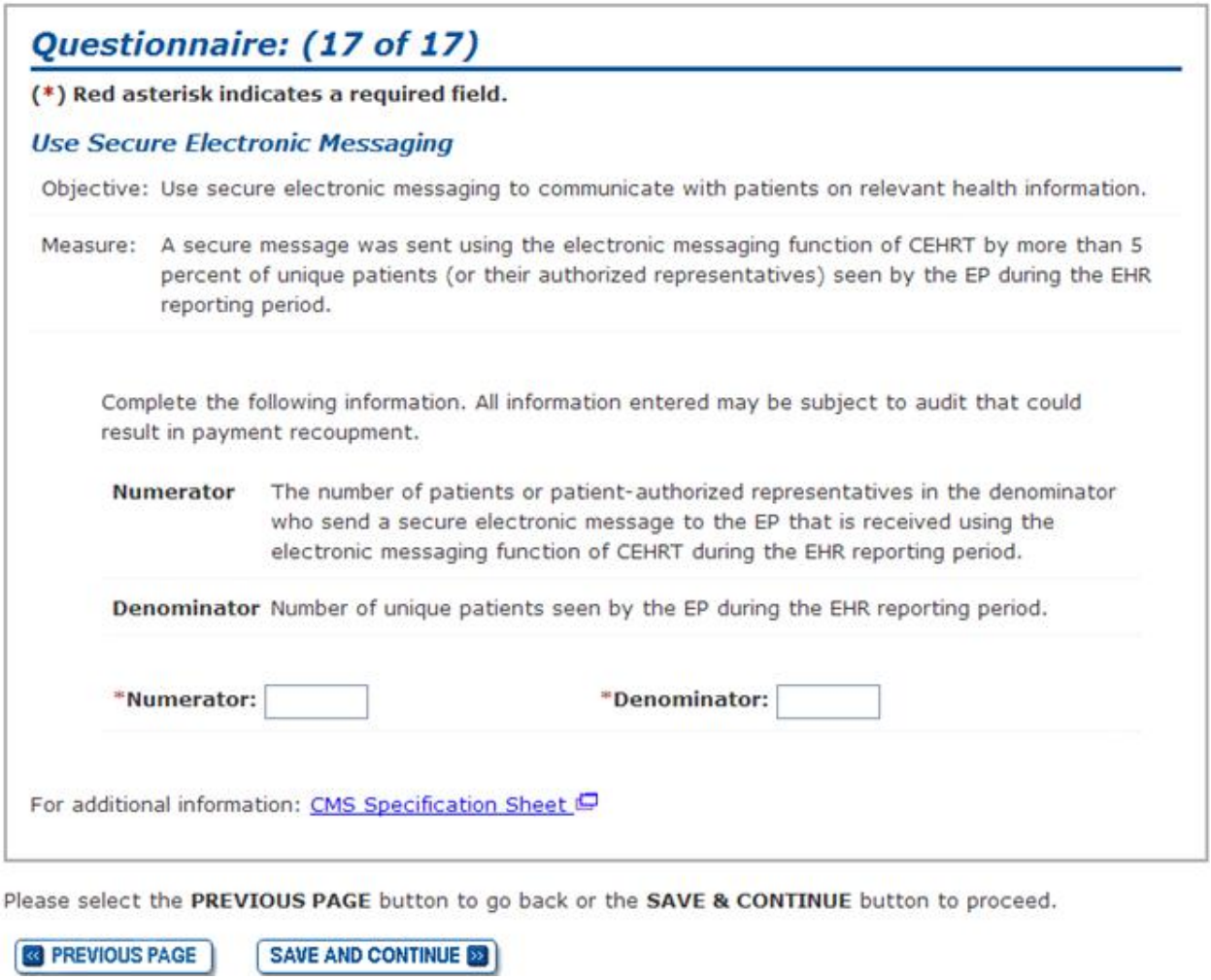


Figure 86 - MU Core Question 17 Numerator & Denominator Entry question

26. Meaningful Use Menu Measures Screen Shots

CMS requires that a minimum of three "menu set" questions are selected. All six questions' screen shots are displayed. The application will only display the questions that are selected by the user.

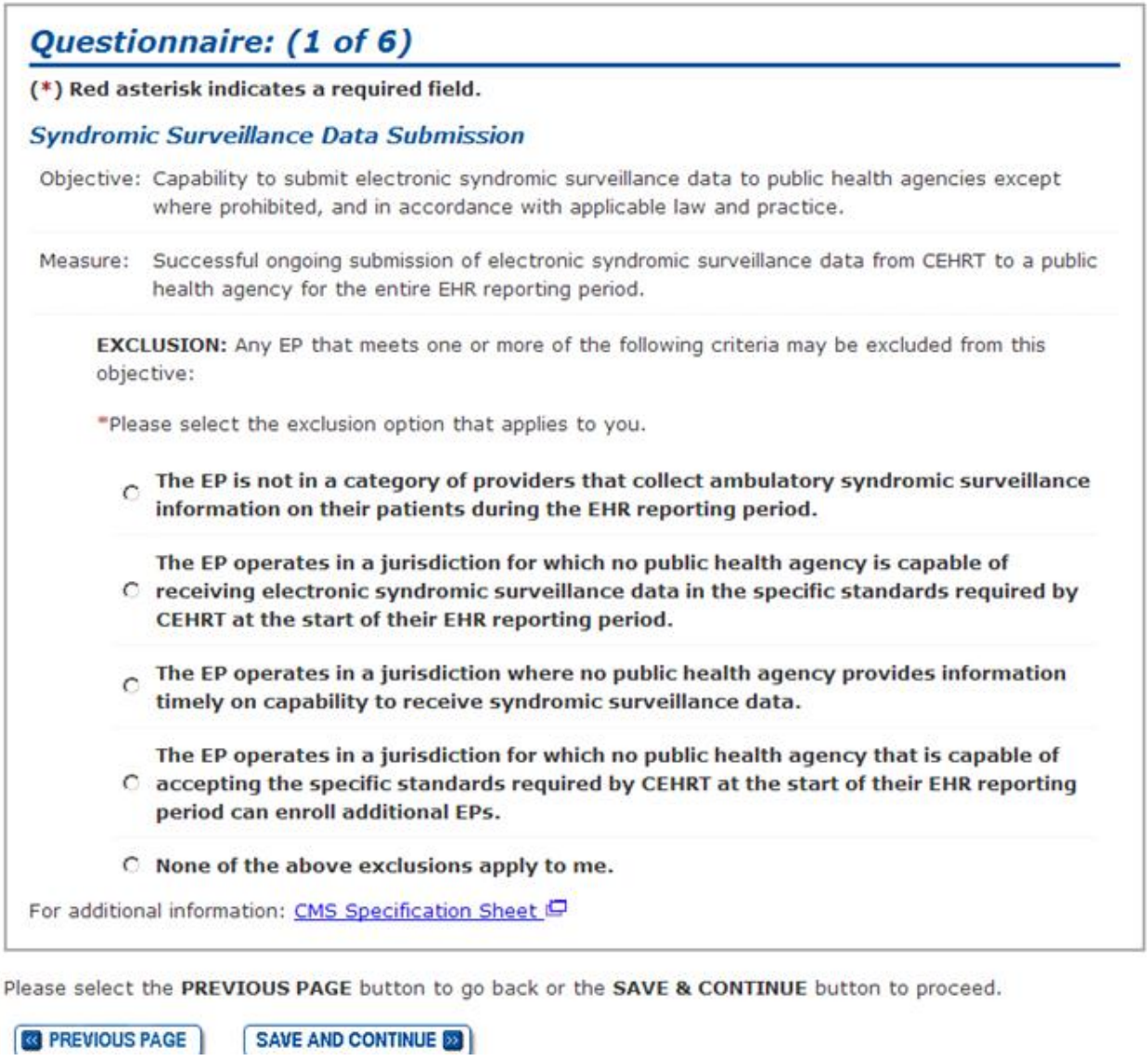


Figure 87 - Menu Measures Question 1 - Syndromic Surveillance Data Submission

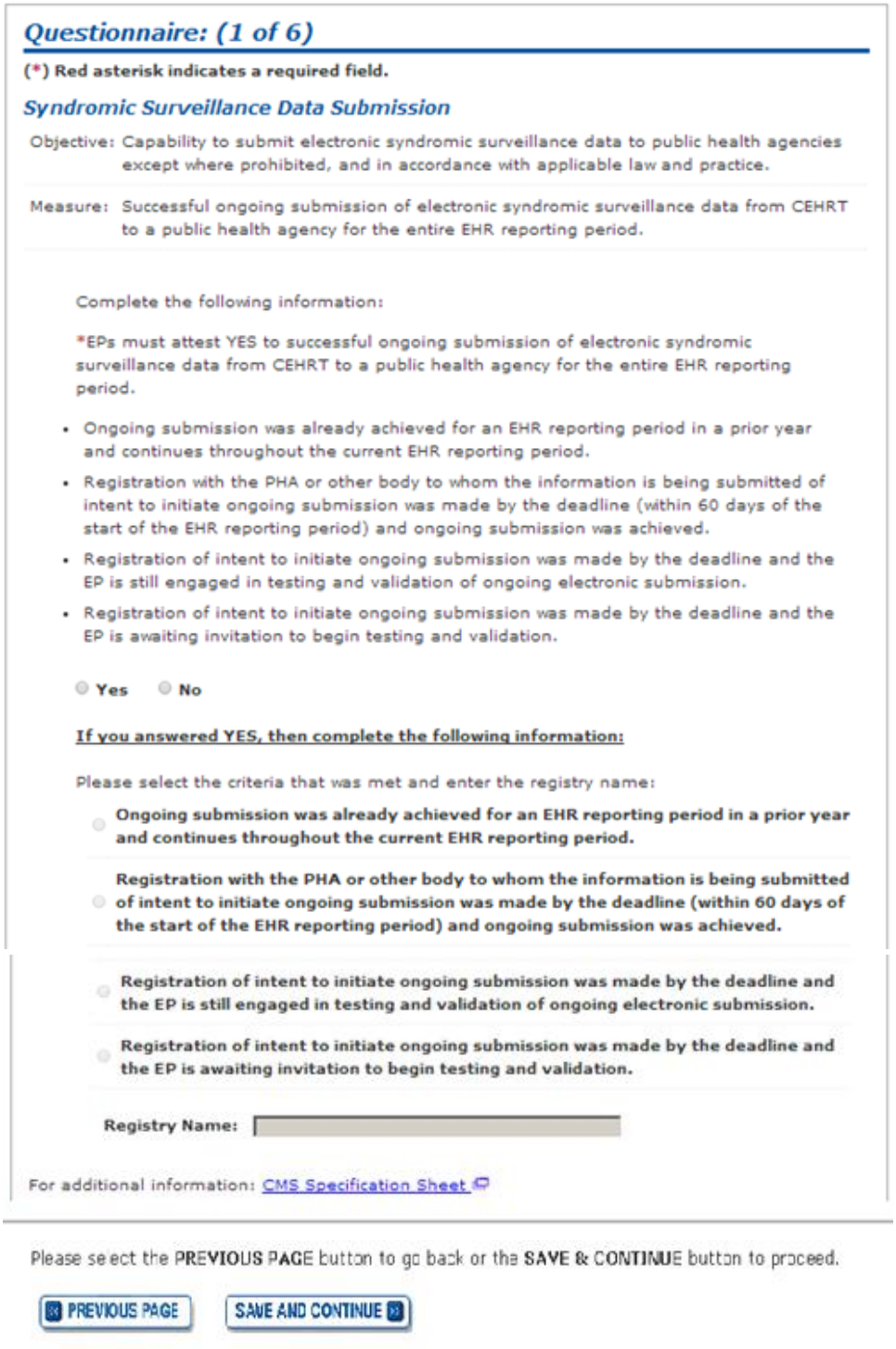


Figure 88 - Menu Measure Question 1 Additional Information Entry Screen

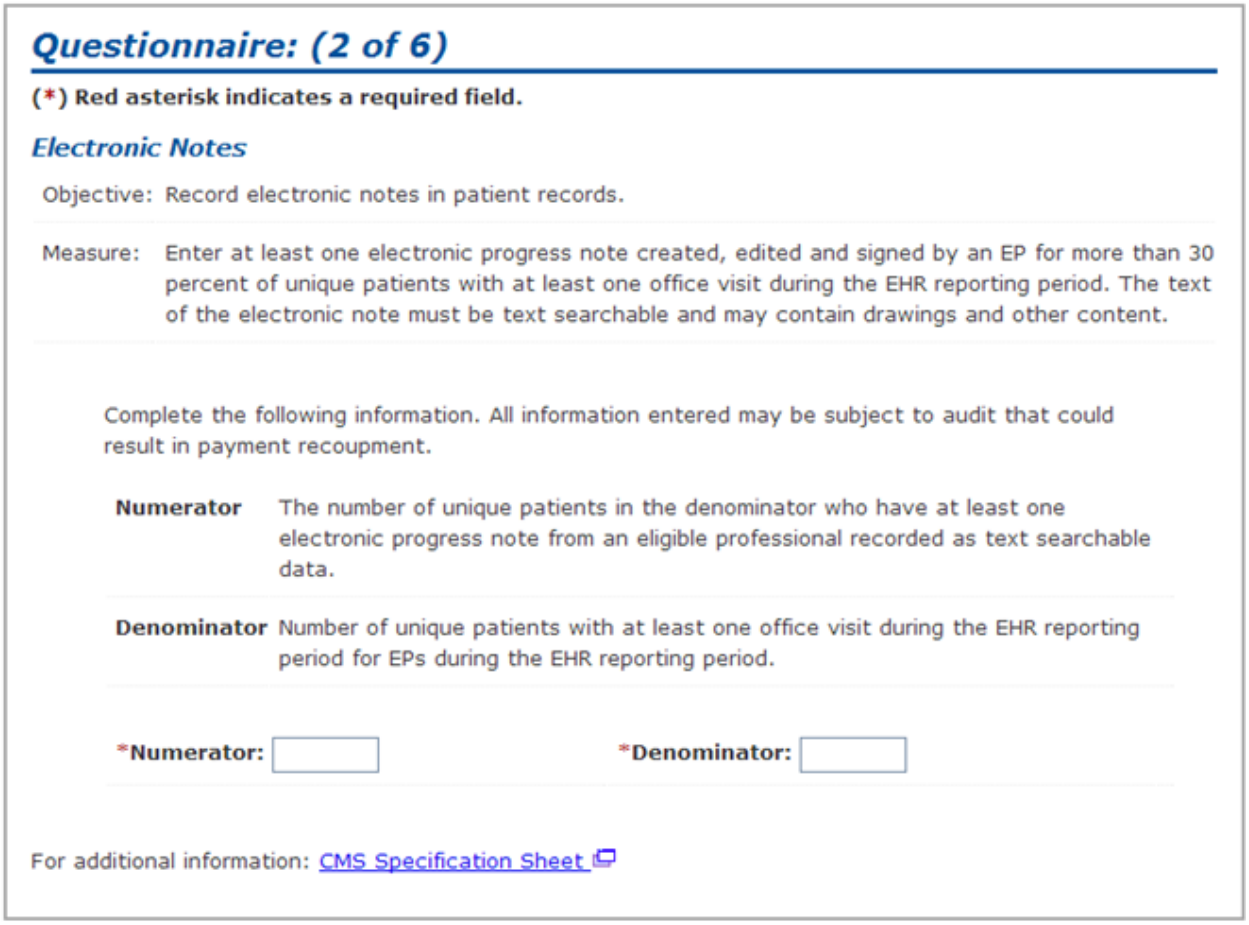


Figure 89 - Menu Measure Question 2 - Electronic Notes

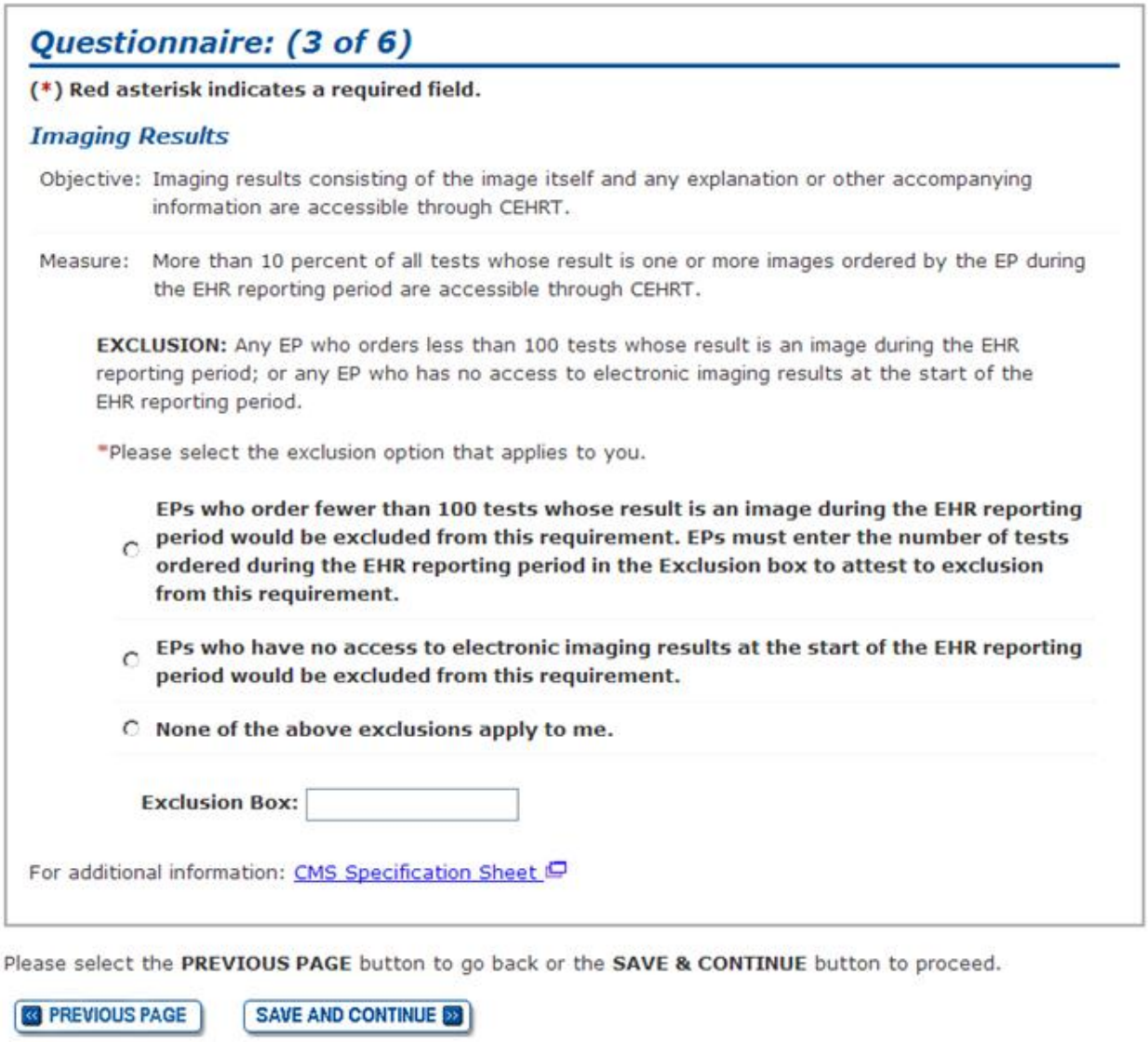


Figure 90 - Menu Measures Question 3 - Imaging Results

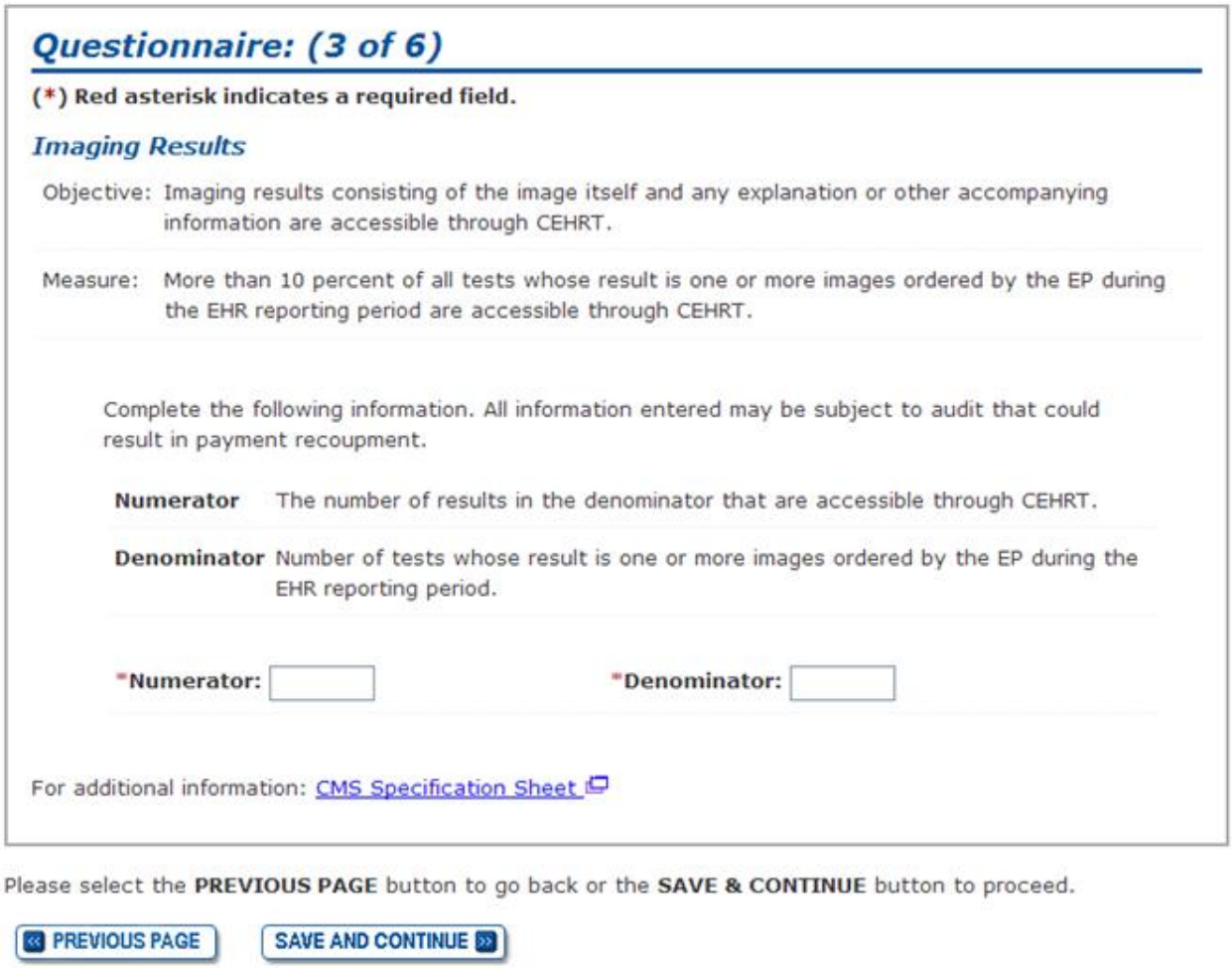


Figure 91 - Menu Measures - Question 3 Numerator & Denominator Entry Screen

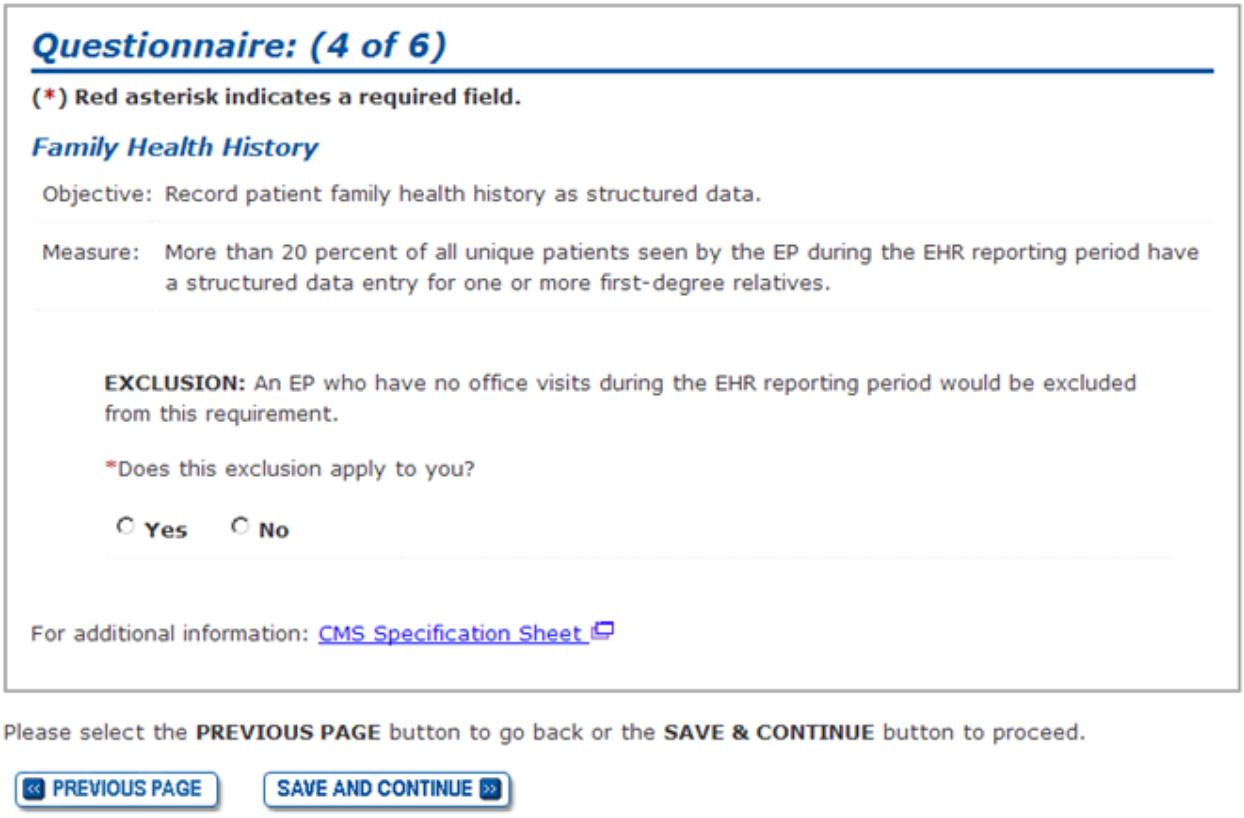


Figure 92- Menu Measures - Question 4 Family Health History

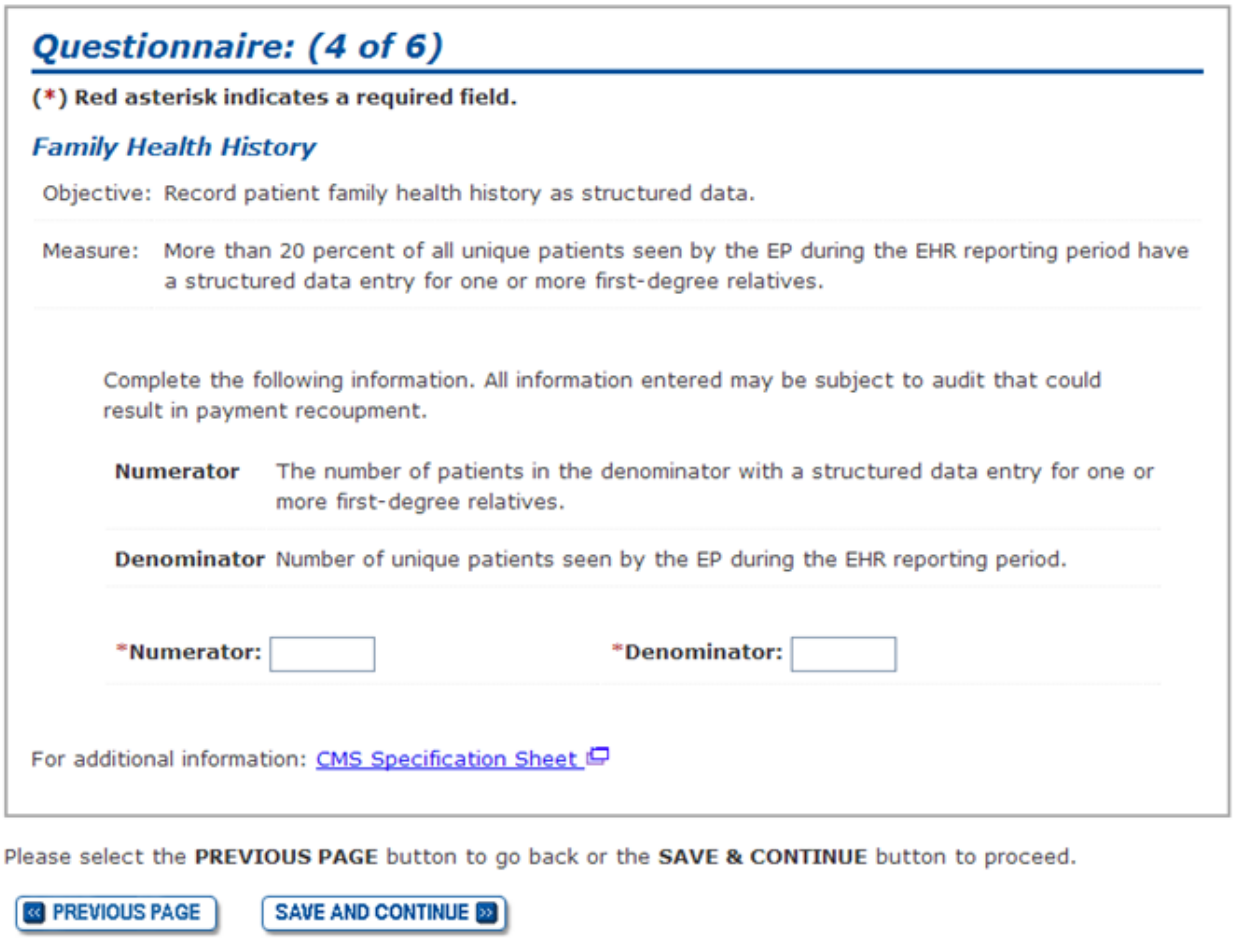


Figure 93 - Menu Measures Question 4 Numerator & Denominator Entry Screen

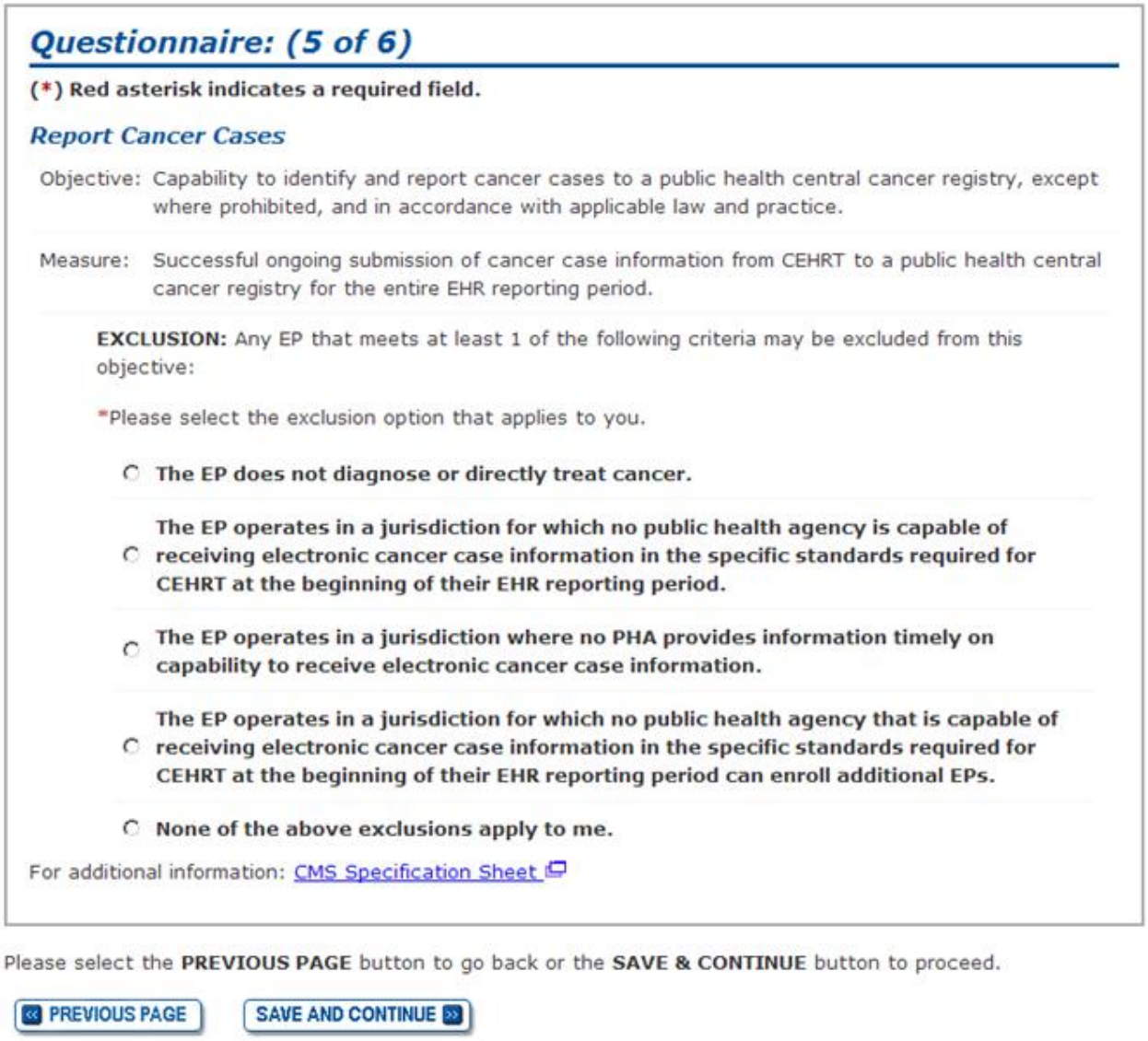


Figure 94 - Menu Measures Question 5 Report Cancer Cases

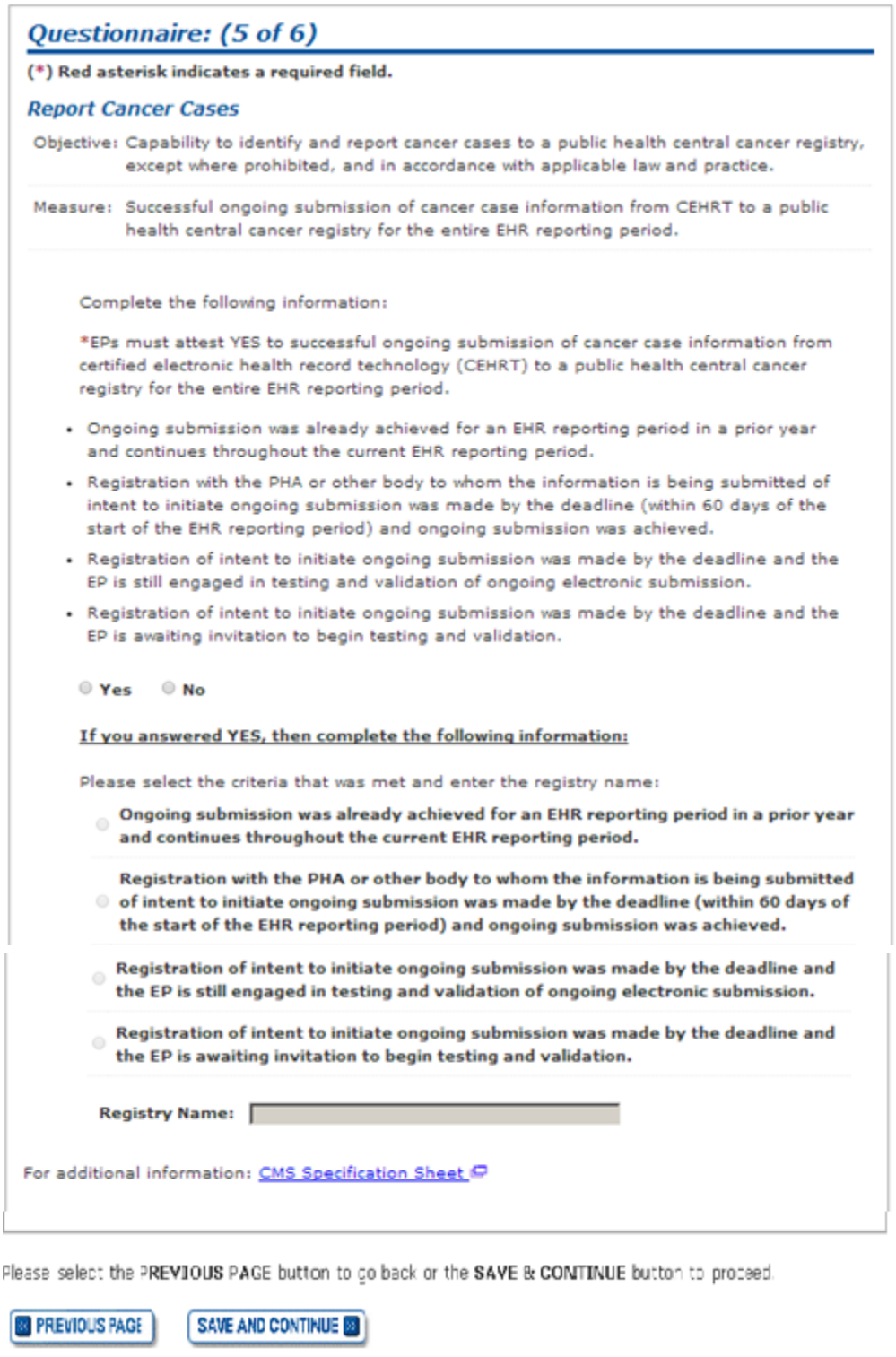


Figure 95 - Menu Measures Question 5 Additional Information Entry Screen

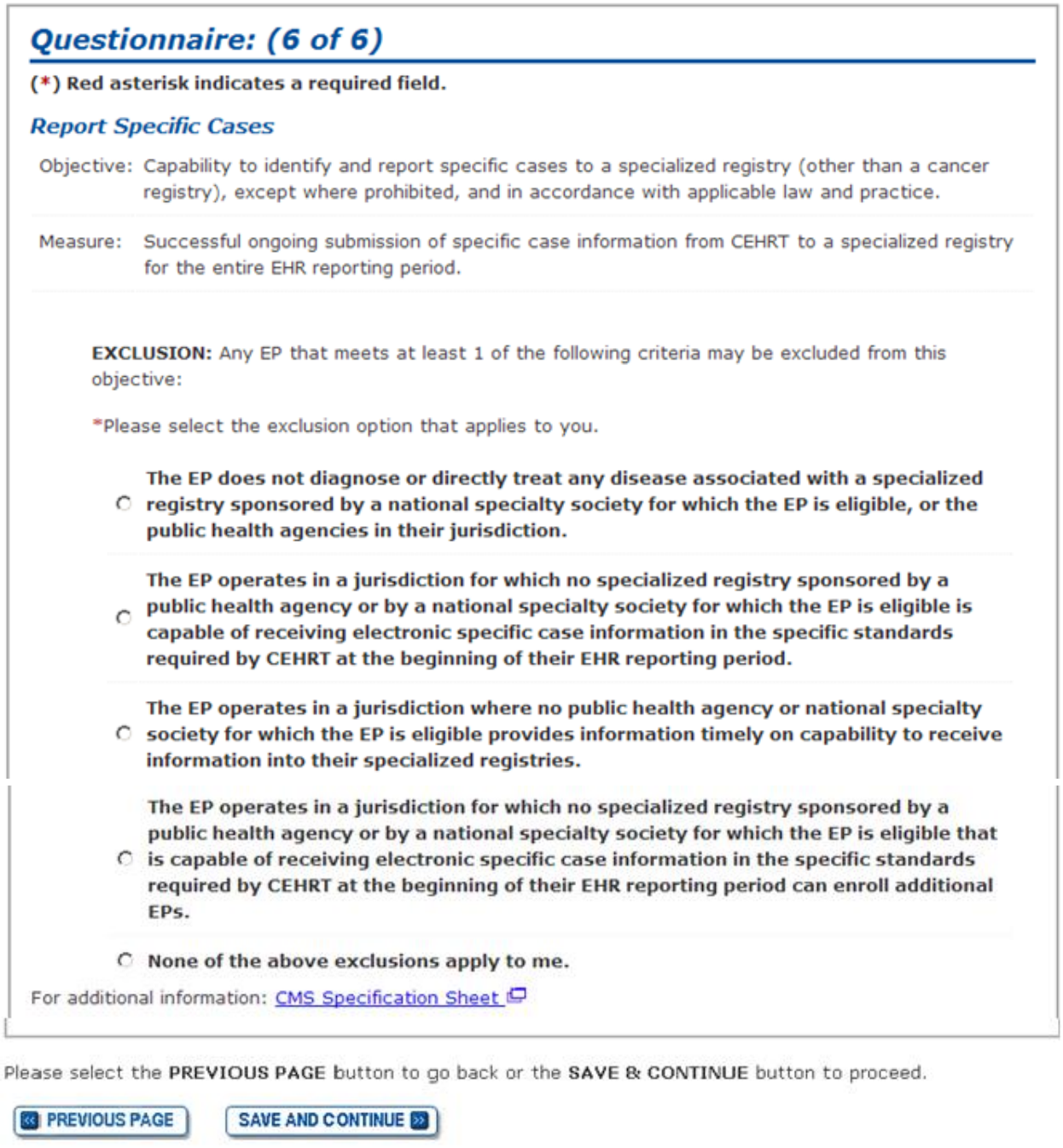


Figure 96 - Menu Measures Question 6 – Report Specific Cases

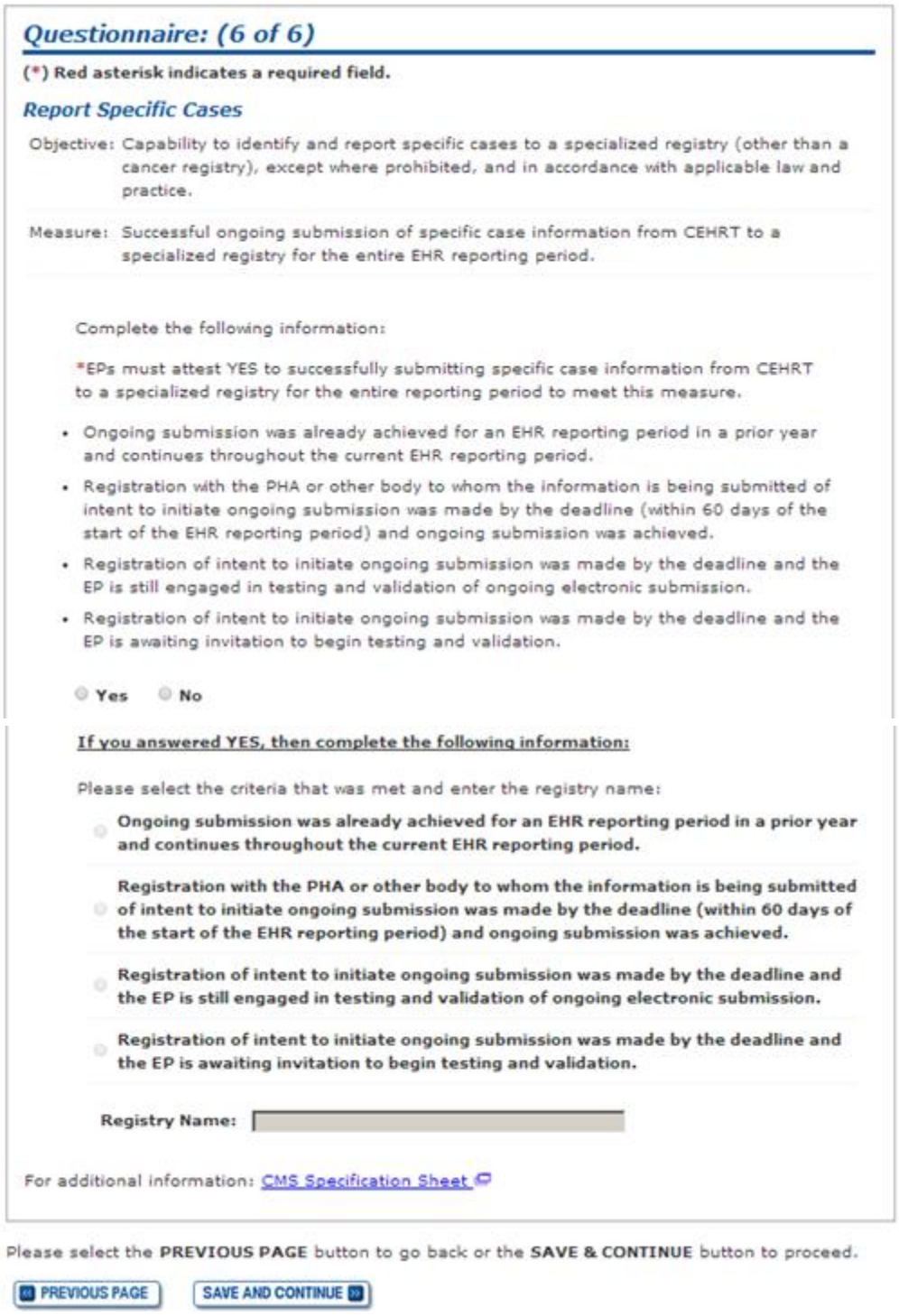


Figure 97 - Menu Measures Question 6 Additional Information Entry Screen

27. Clinical Quality Measures Screen Shots

Below are screen shots for the 64 CQMs that are available for selection.

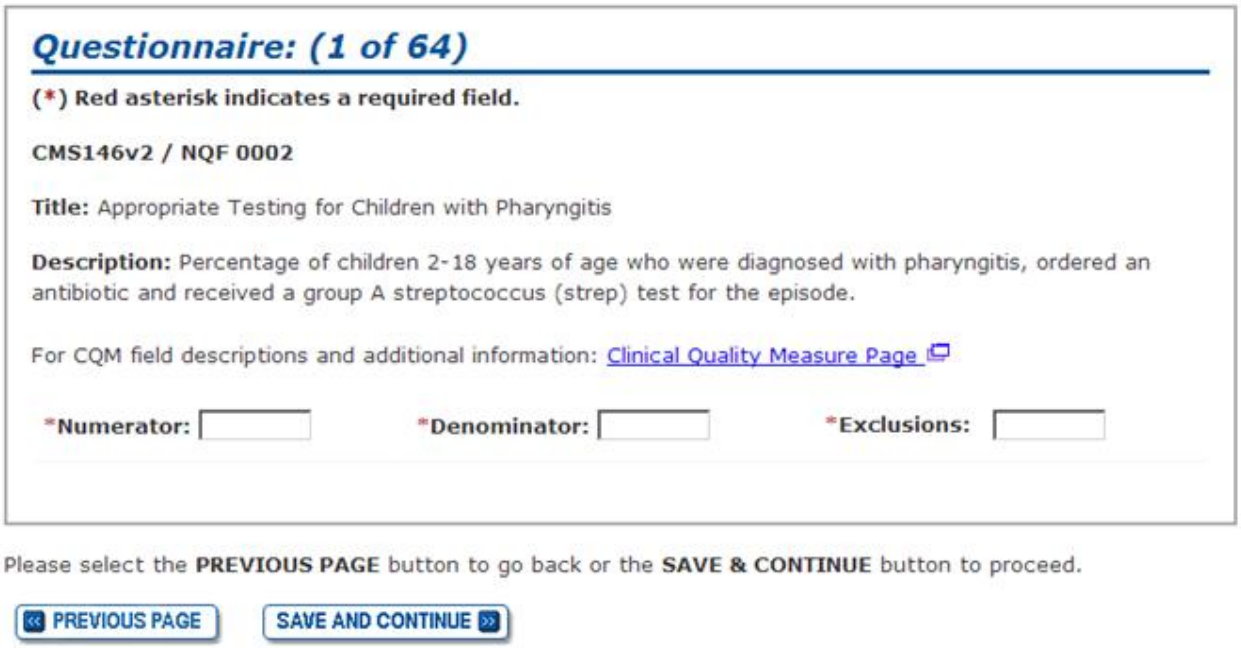


Figure 98 - CQM Question 1 Appropriate Testing for Children with Pharyngitis

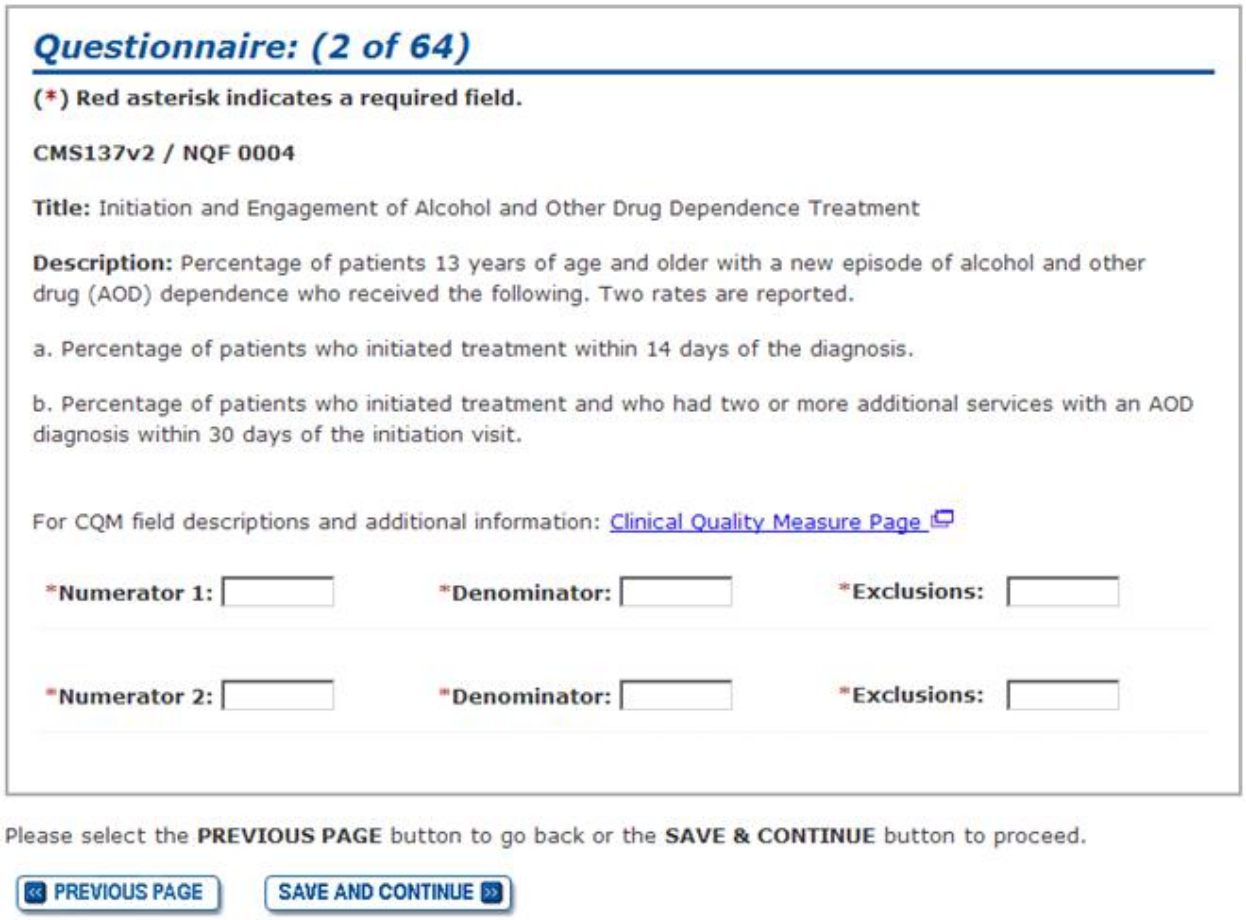


Figure 99 - CQM Question 2 Initiation and Engagement of Alcohol & Other Drug Dependence Treatment

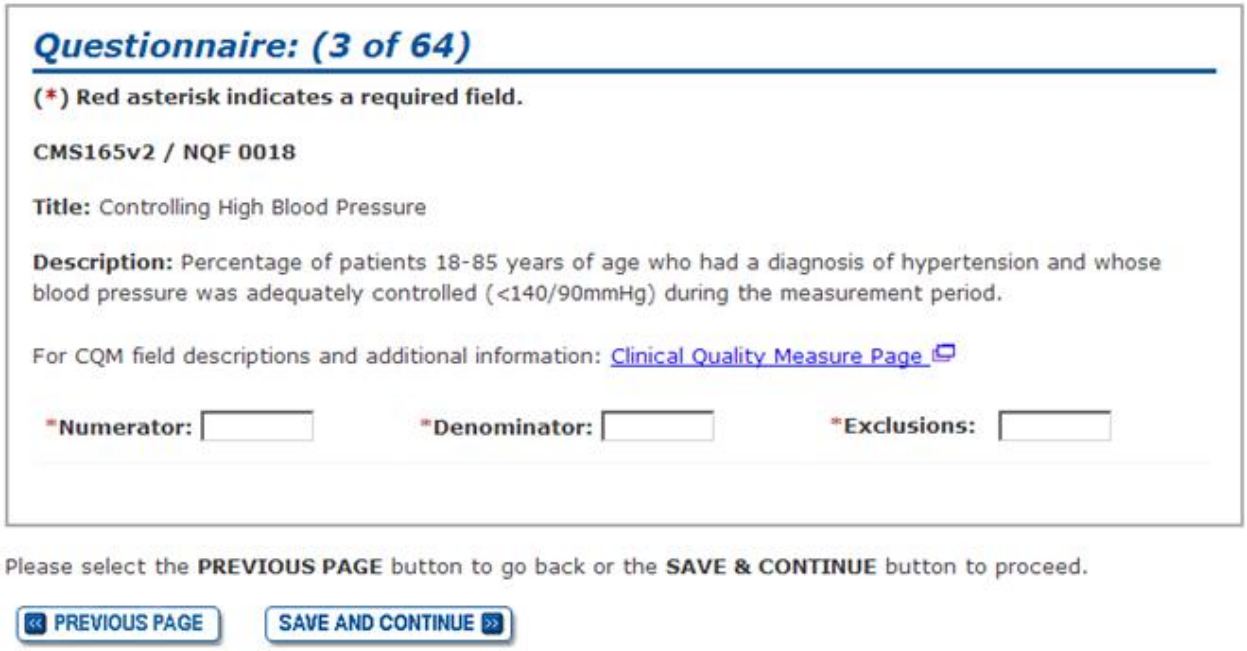


Figure 100 - CQM Question 3 Controlling High Blood Pressure

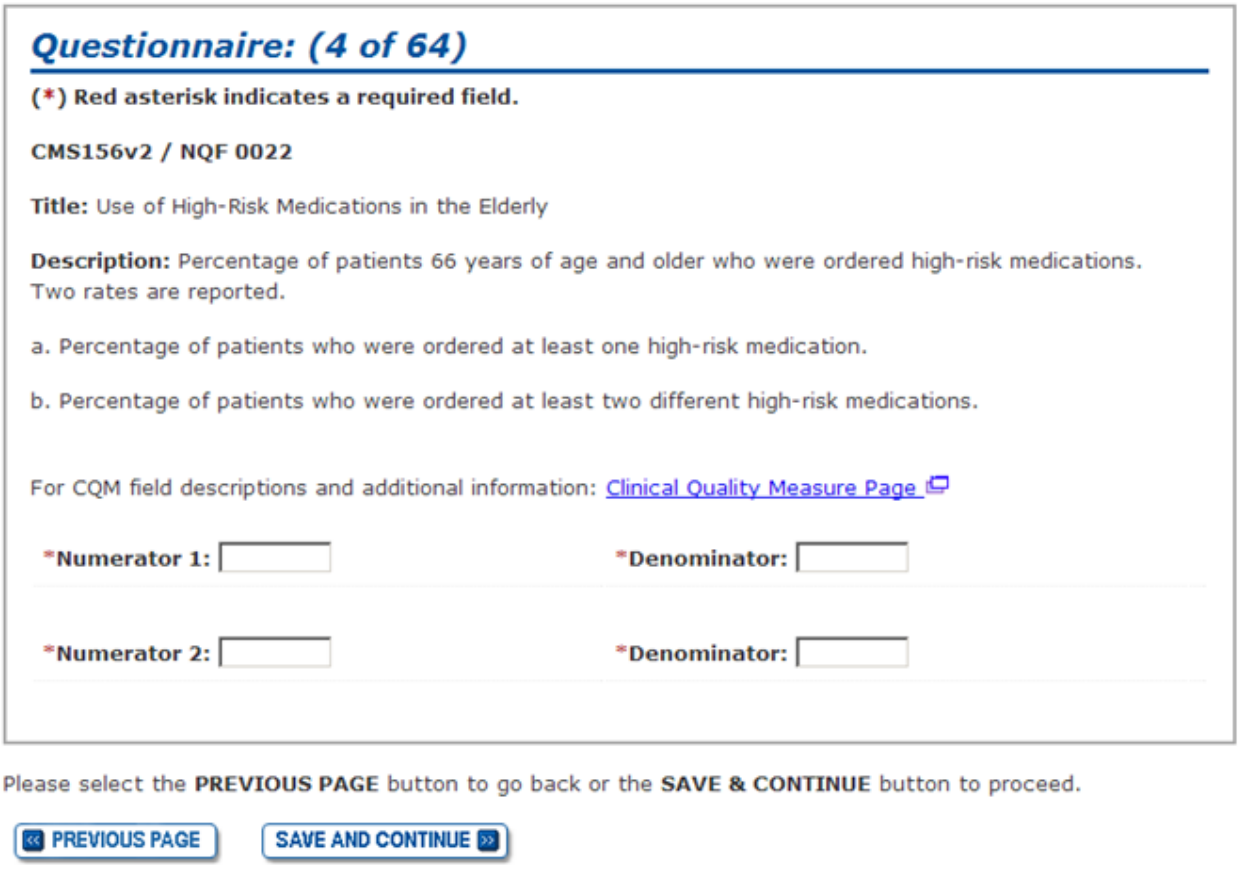


Figure 101 - CQM Question 4 Use of High-Risk Medications in the Elderly

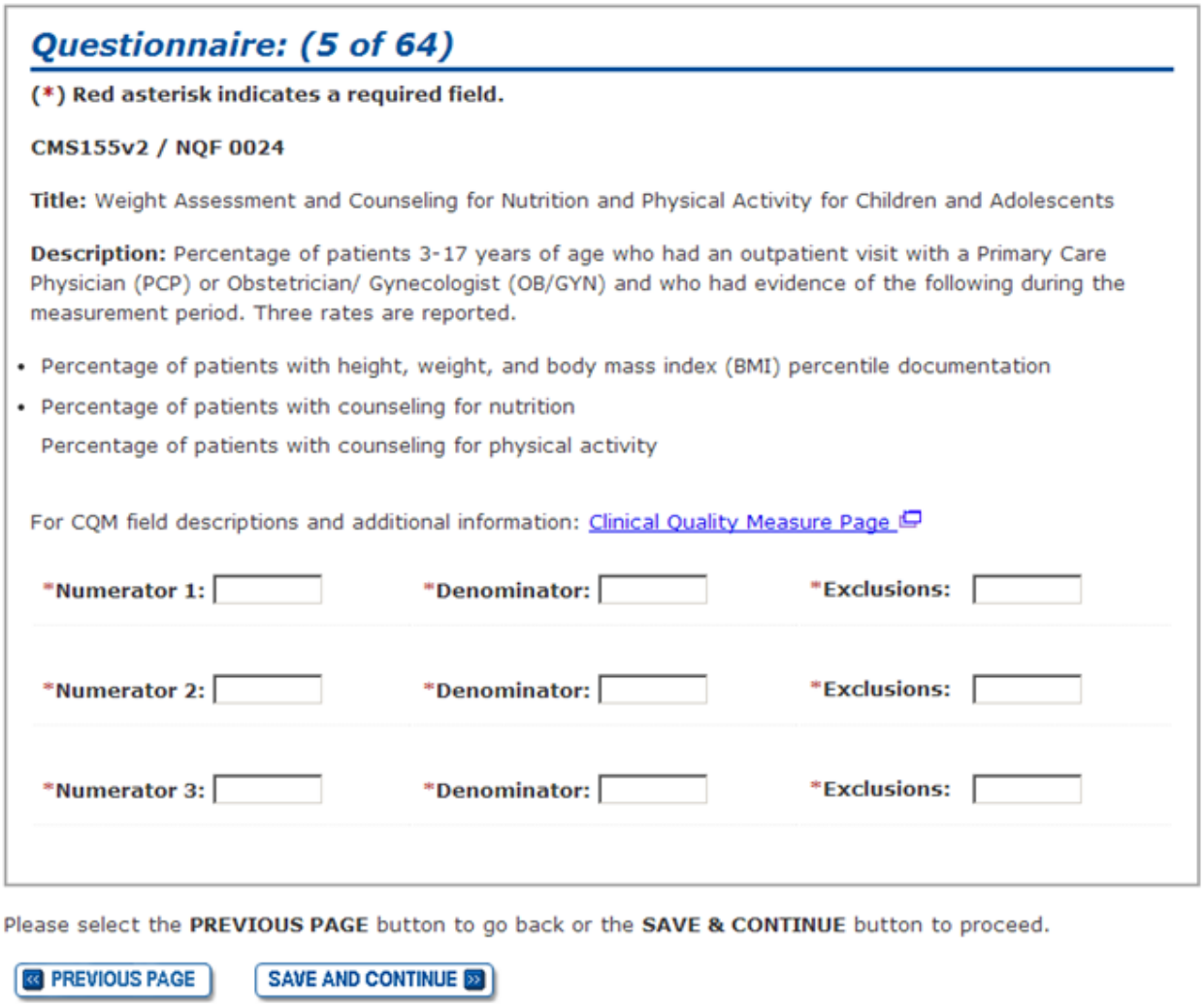


Figure 102 - CQM Question 5 Weight Assessment and Counseling for Nutritional & Physical activity for Children and Adolescents

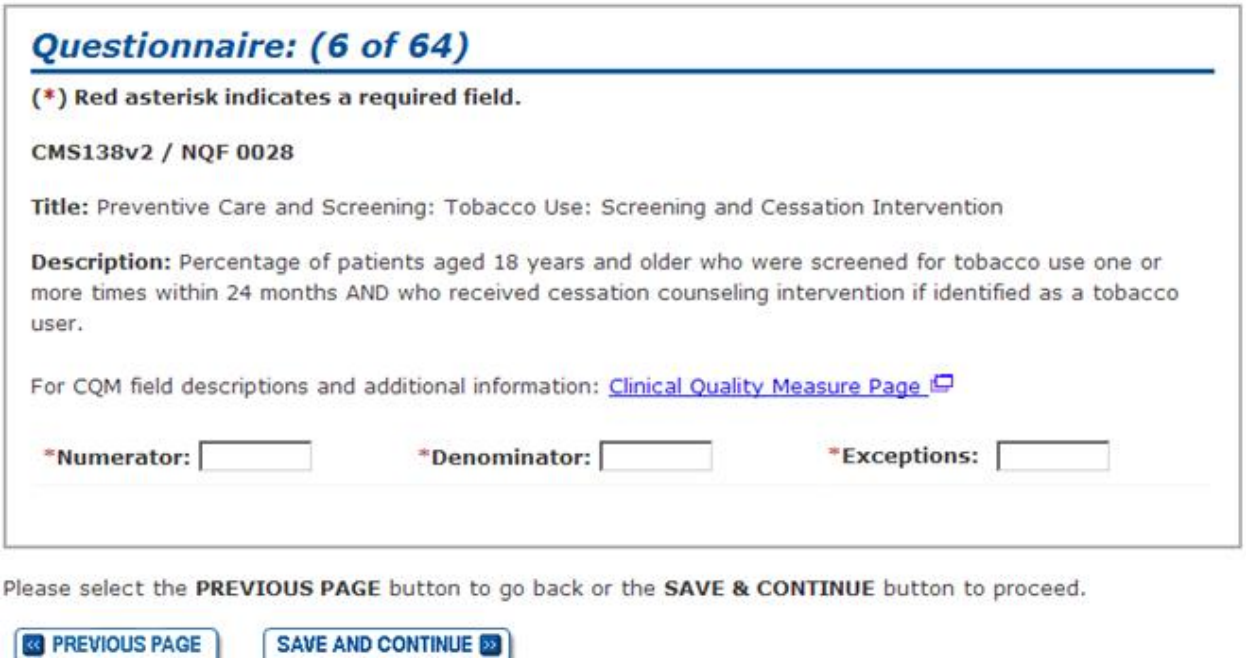


Figure 103 - CQM Question 6 Preventive Care and Screening: Tobacco use: Screening and Cessation Intervention

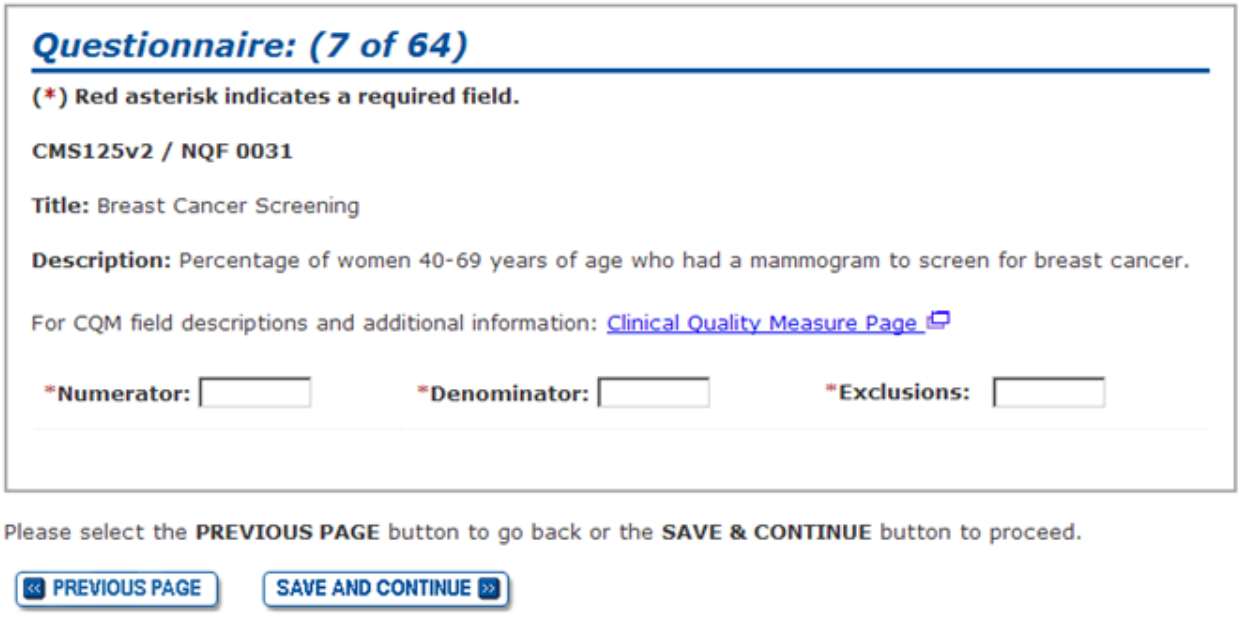


Figure 104 - CQM Question 7 Breast Cancer Screening

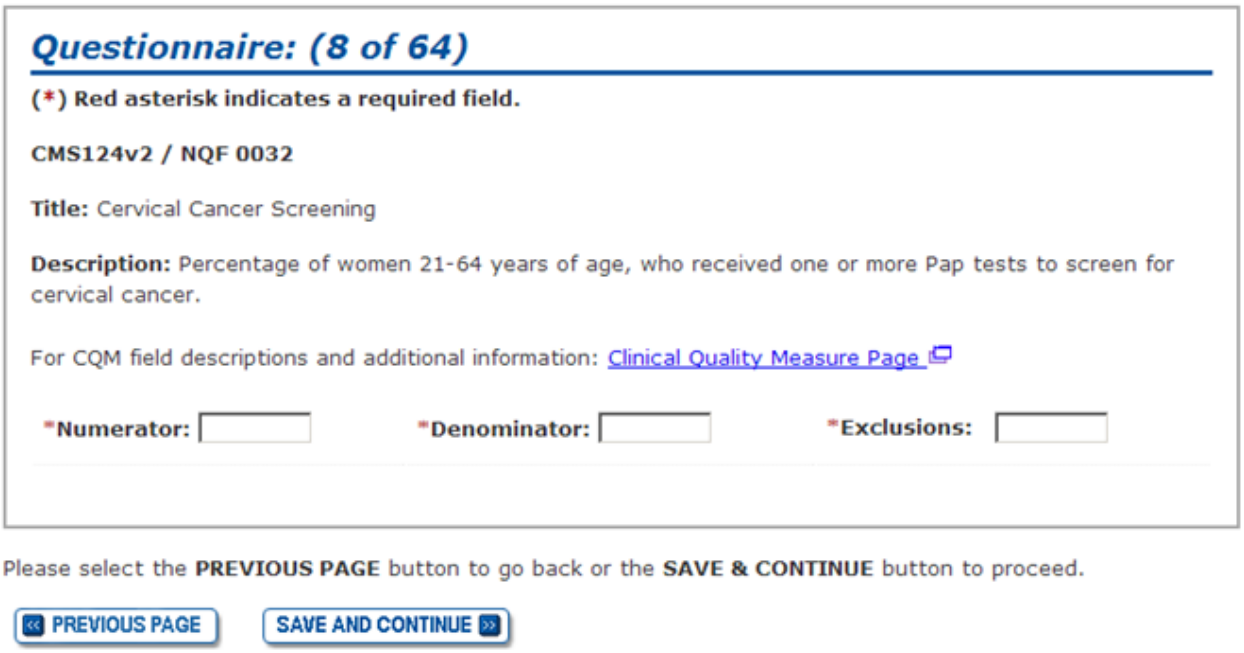


Figure 105 - CQM Question 8 Cervical Cancer Screening

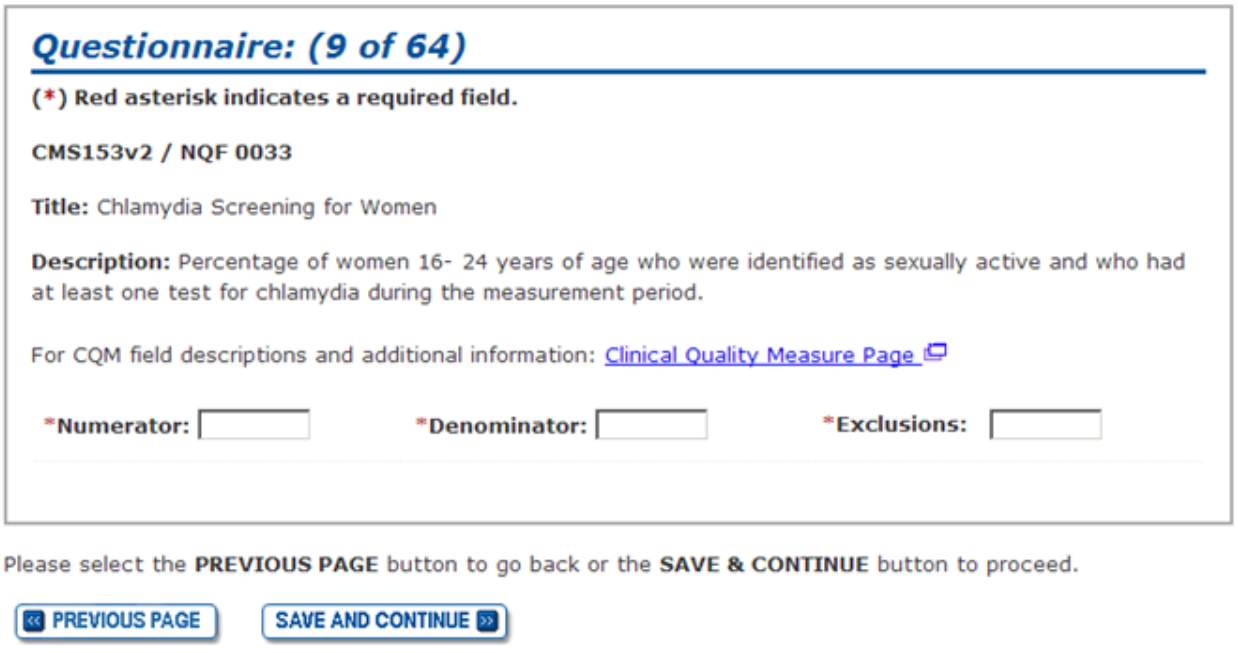


Figure 106 - CQM Question 9 Chlamydia Screening for Women

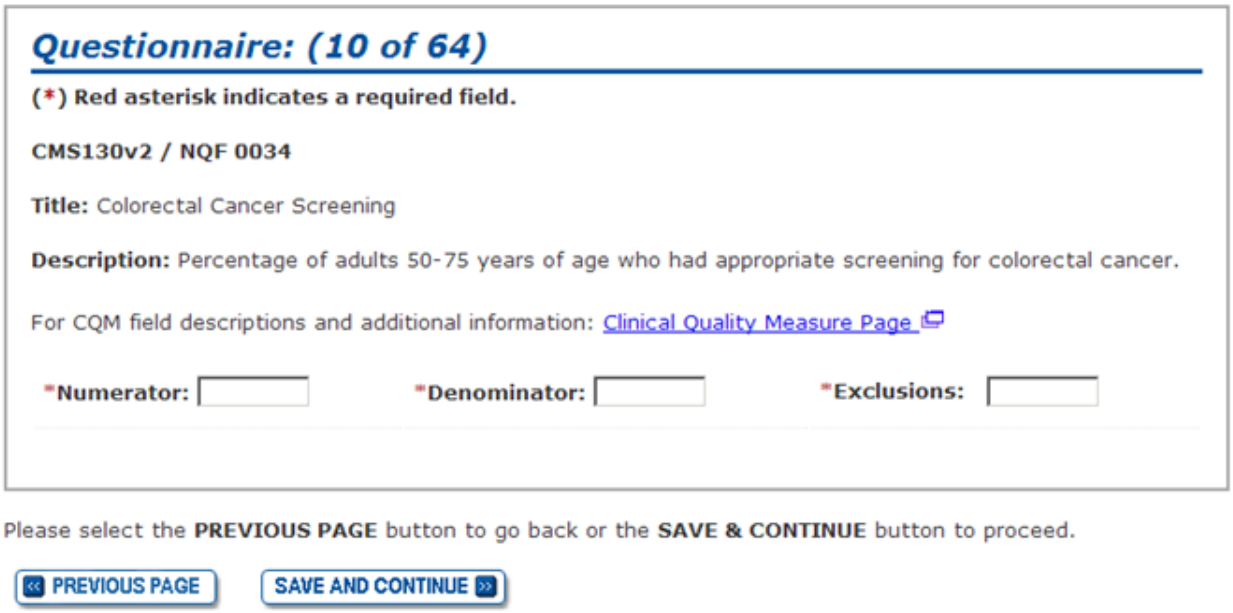


Figure 107 - CQM Question 10 Colorectal Cancer Screening

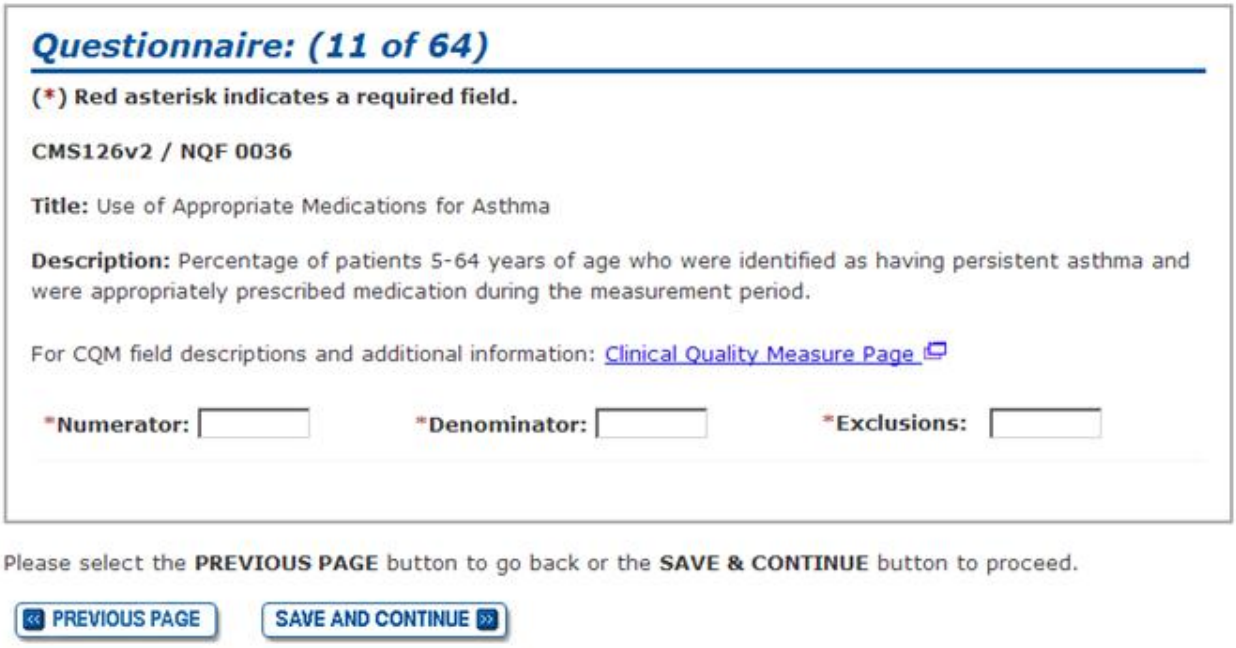


Figure 108 - CQM Question 11 Use of Appropriate Medications for Asthma

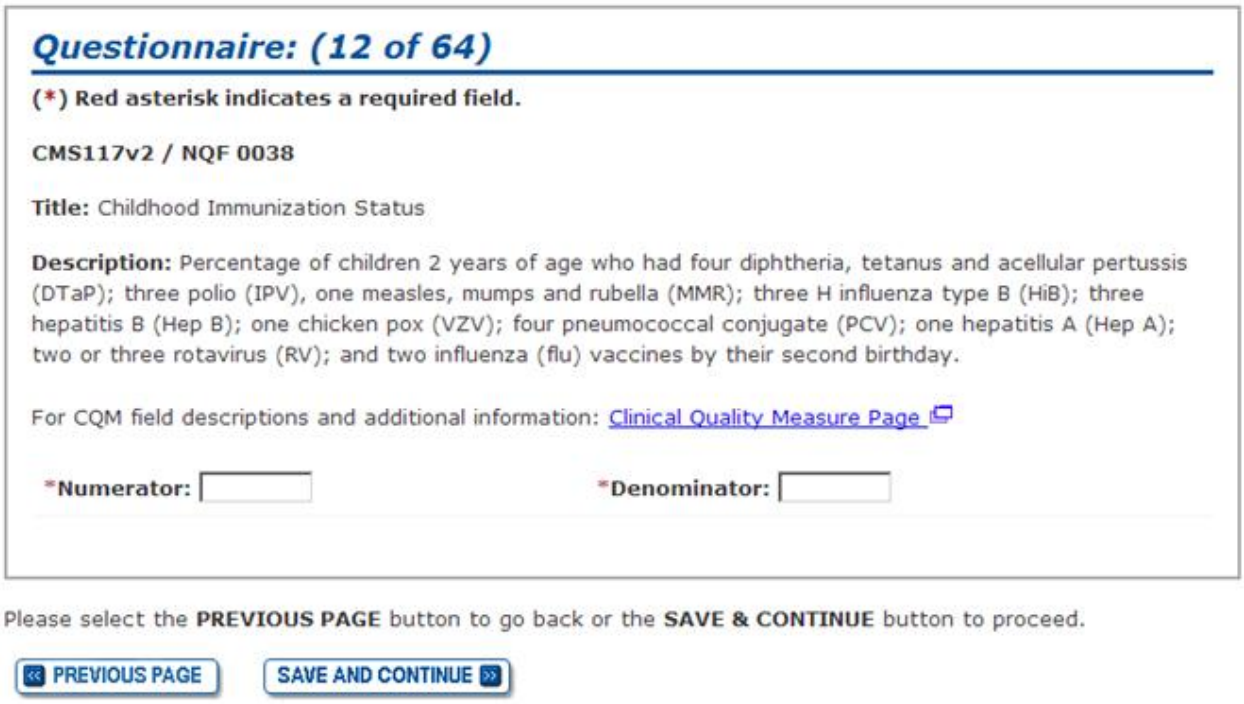


Figure 109 - CQM Question 12 Childhood Immunization Status

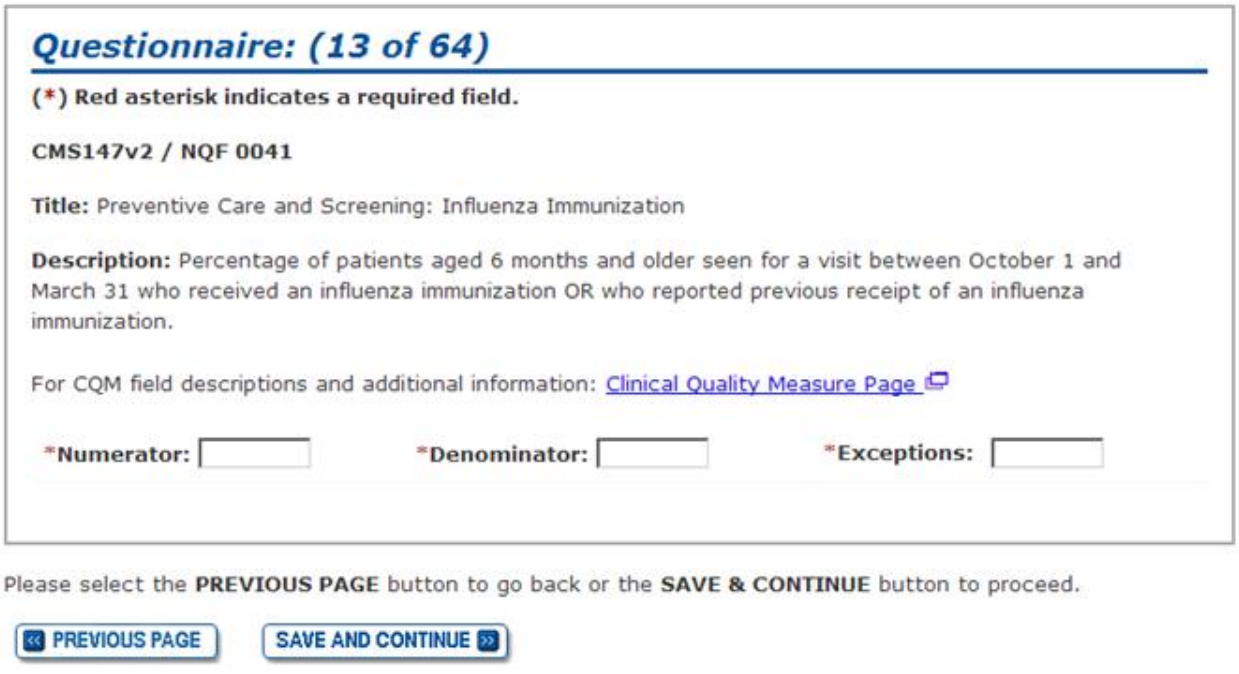


Figure 1 - CQM Question 13 Preventive Care and Screening: Influenza Immunization

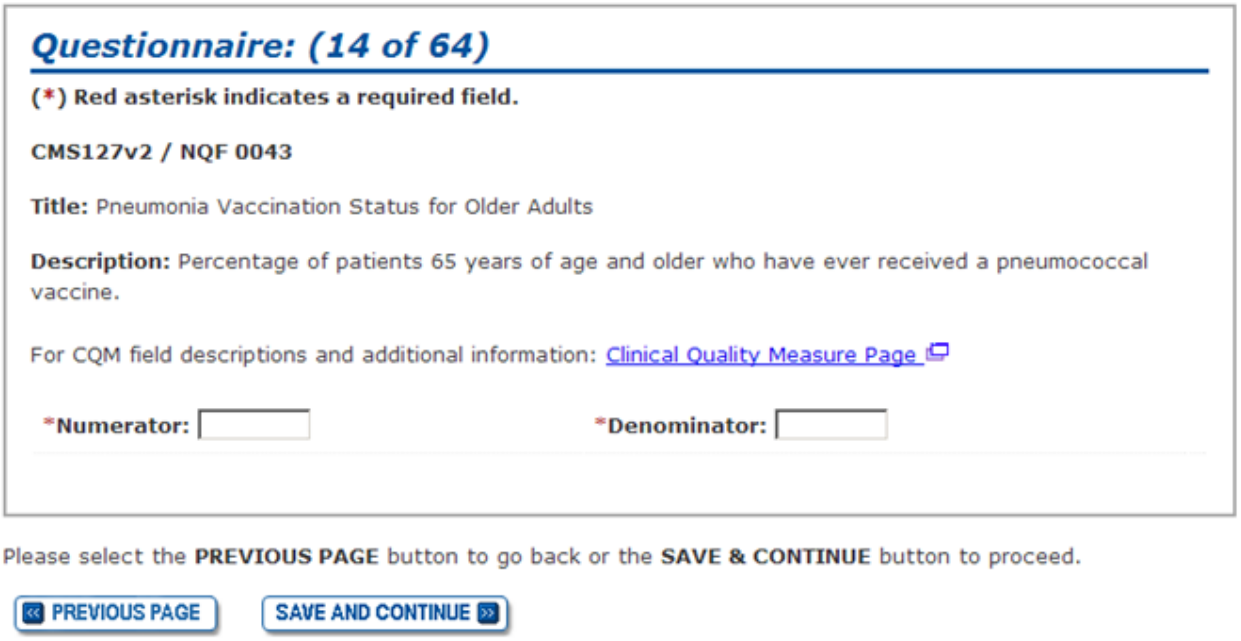


Figure 111 - CQM Question 14 Pneumonia Vaccination Status for Older Adults

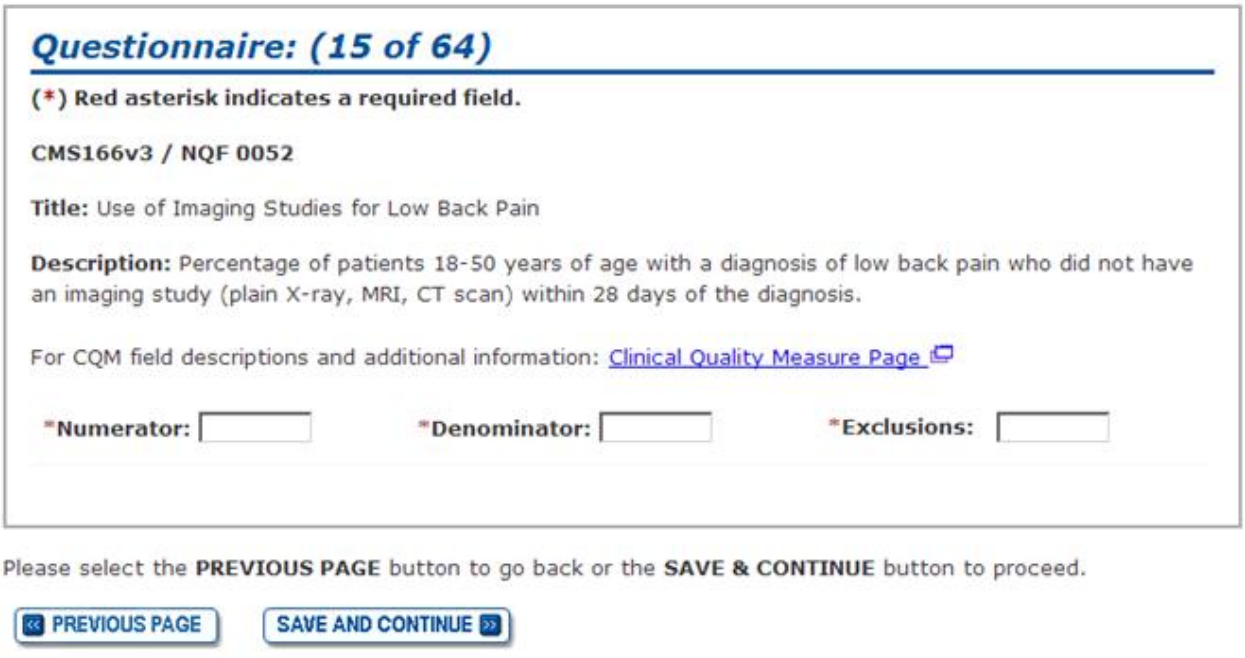


Figure 112 - CQM Question 15 Use of Imaging Studies for Low Back Pain

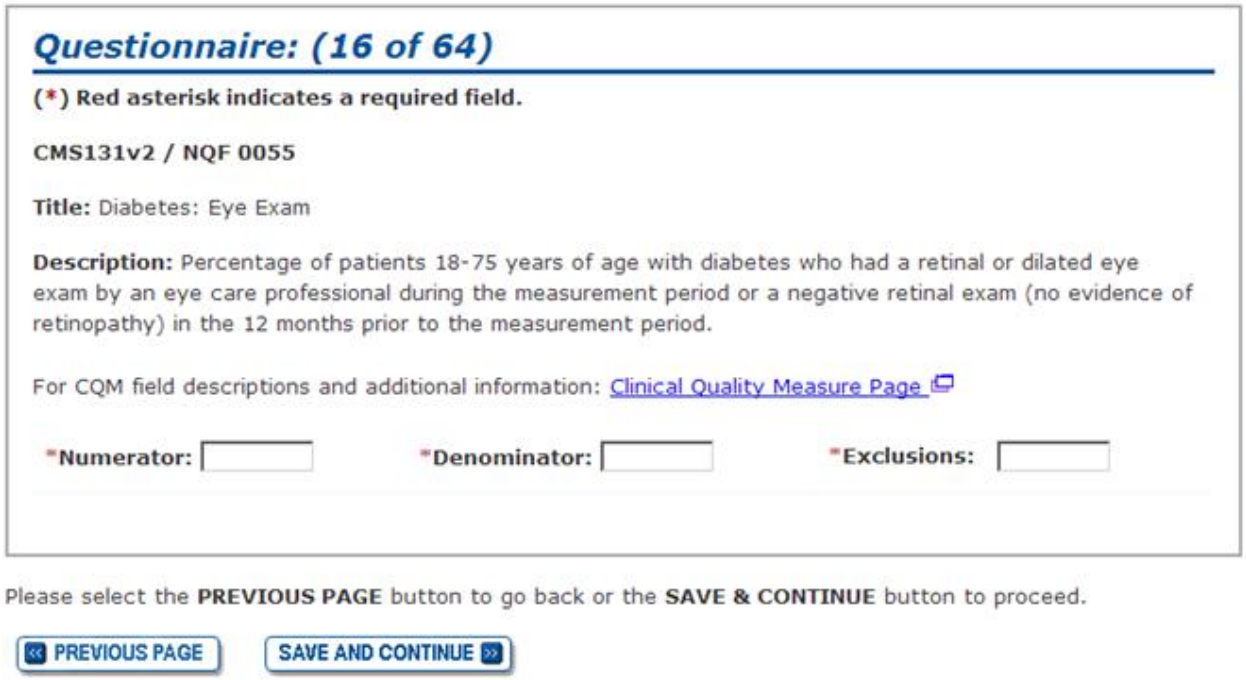


Figure 113 - CQM Question 16 Diabetes: Eye Exam

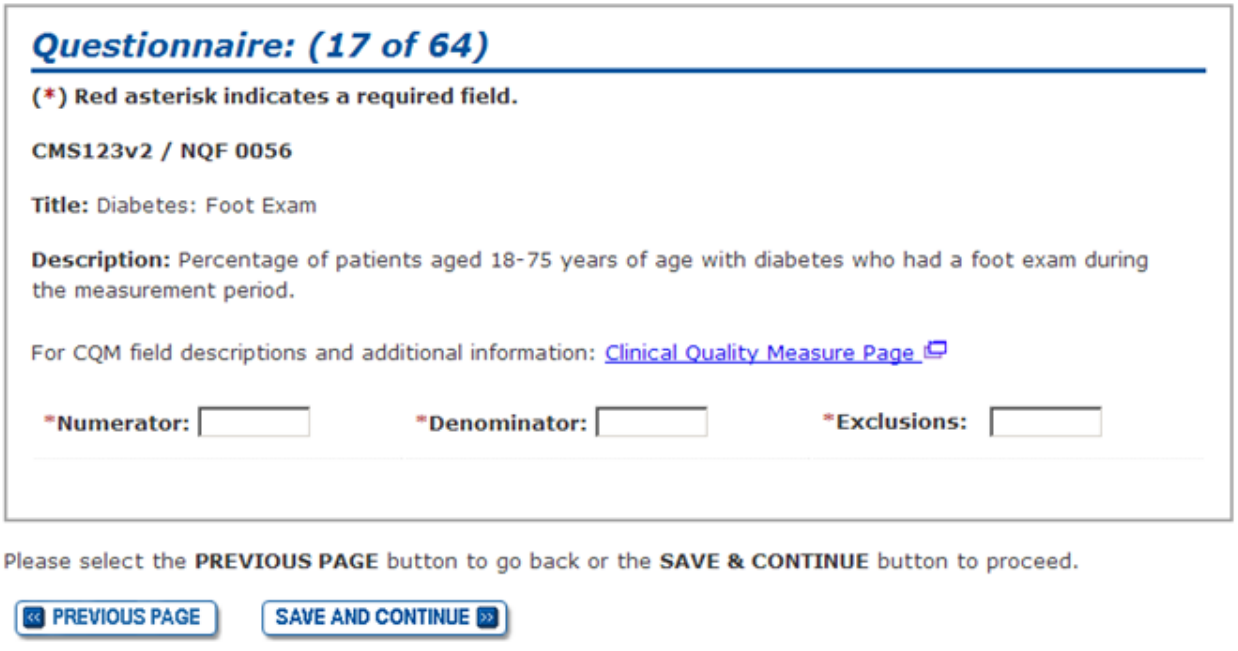


Figure 114 - Question 17 Diabetes: Foot Exam

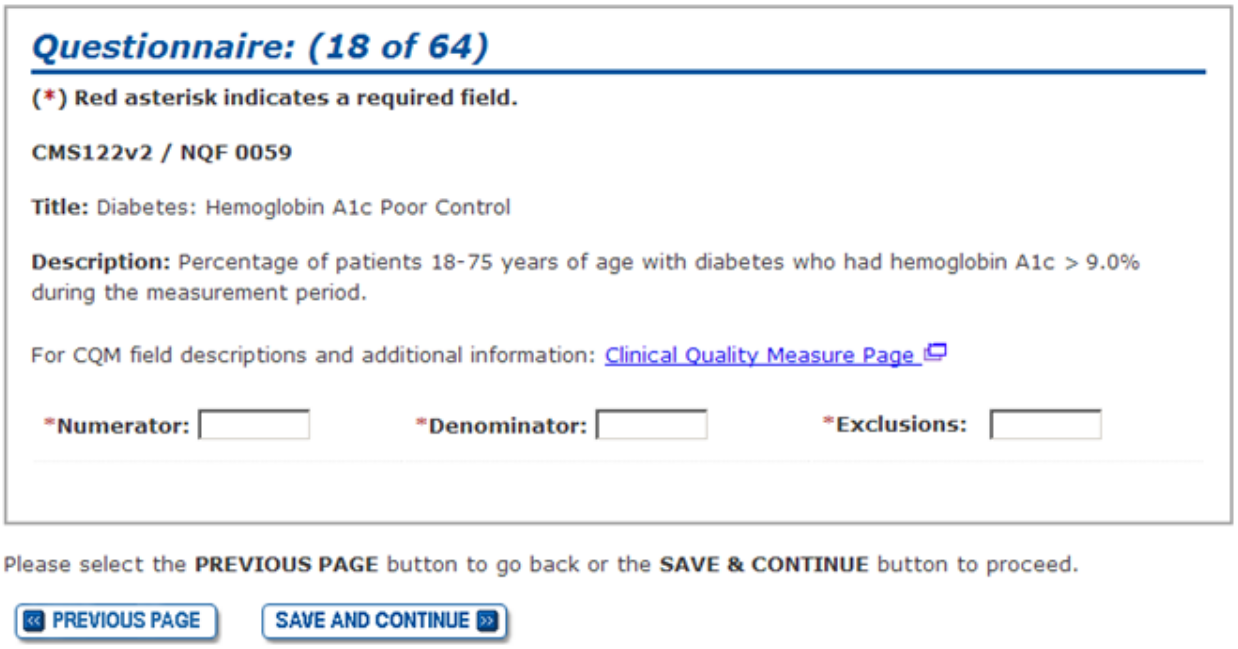


Figure 115 - CQM Question 18 Diabetes: Hemoglobin A1C Poor Control

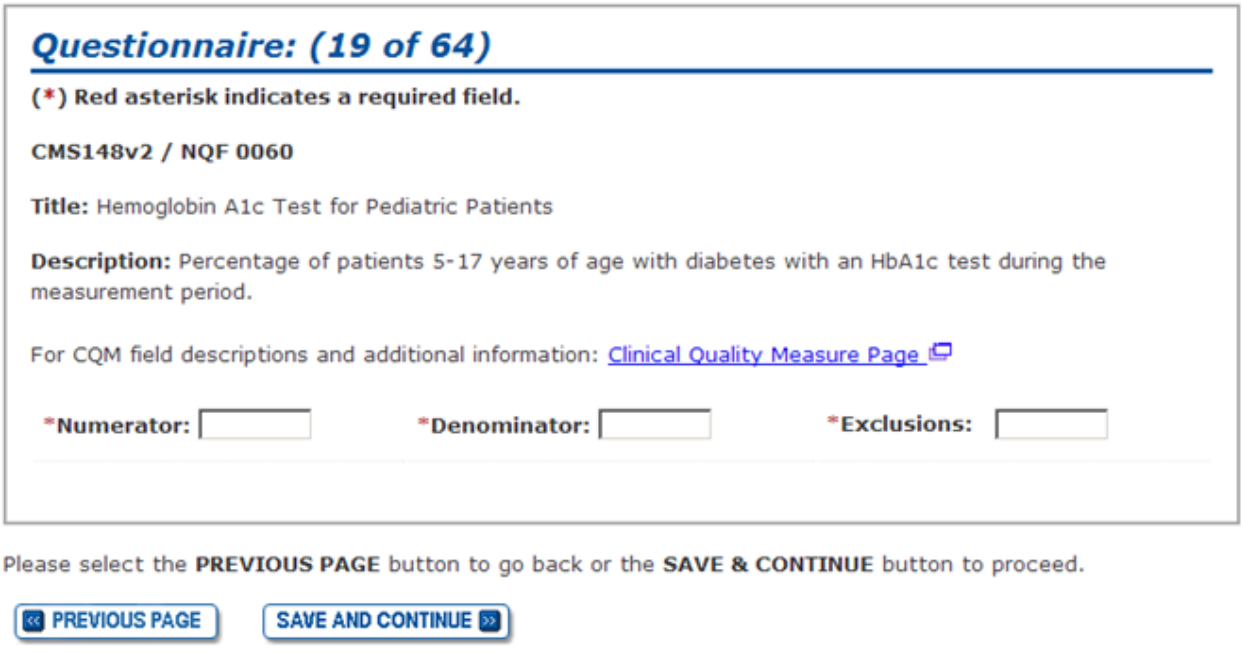


Figure 116 - CQM Question 19 Hemoglobin A1C test for Pediatric Patients

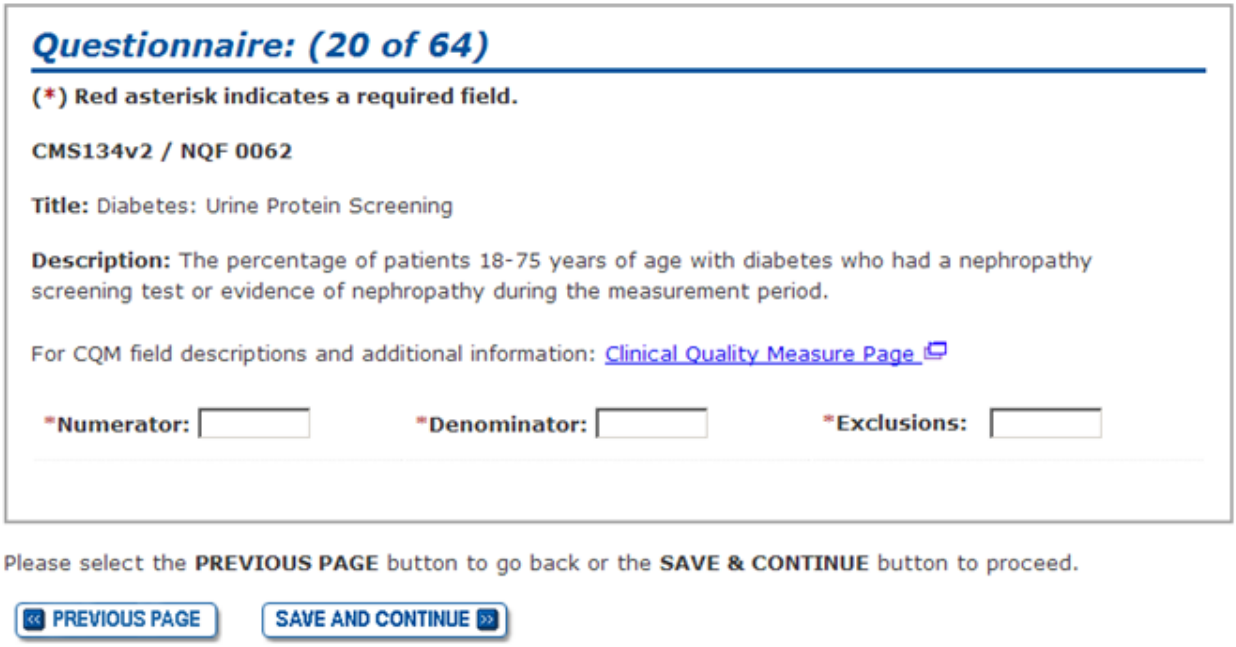


Figure 117 - CQM Question 20 Diabetes: Urine Protein Screening

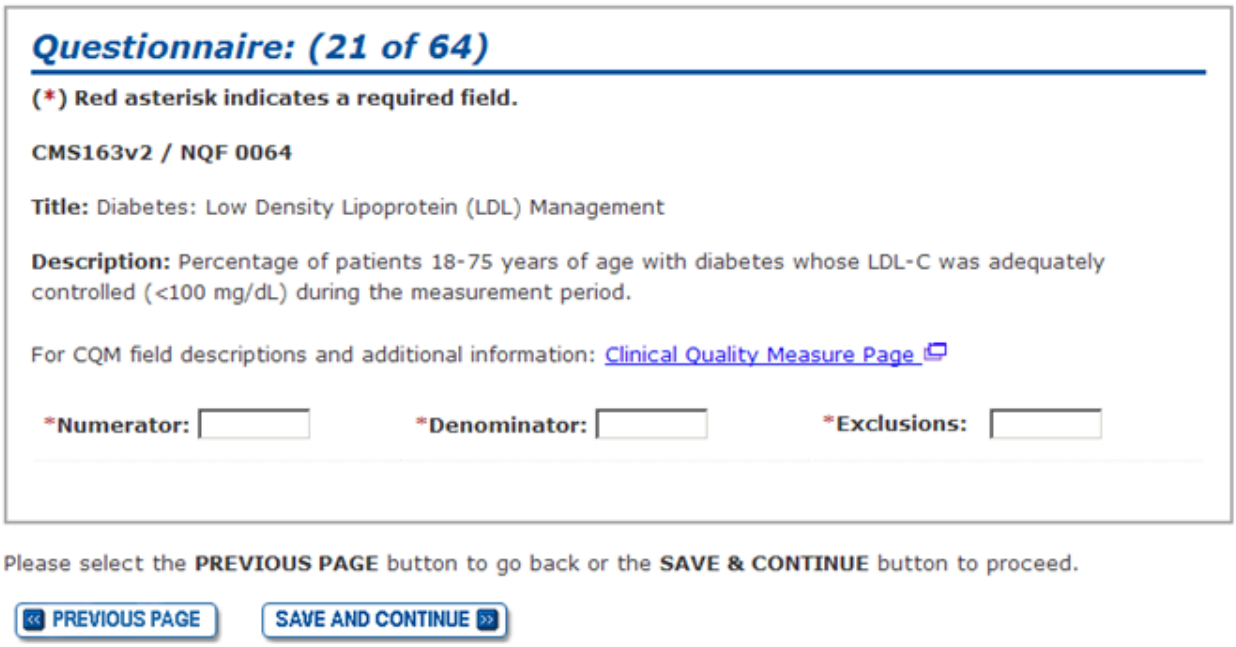


Figure 118 - CQM Question 21 Diabetes: Low Density LDL Management

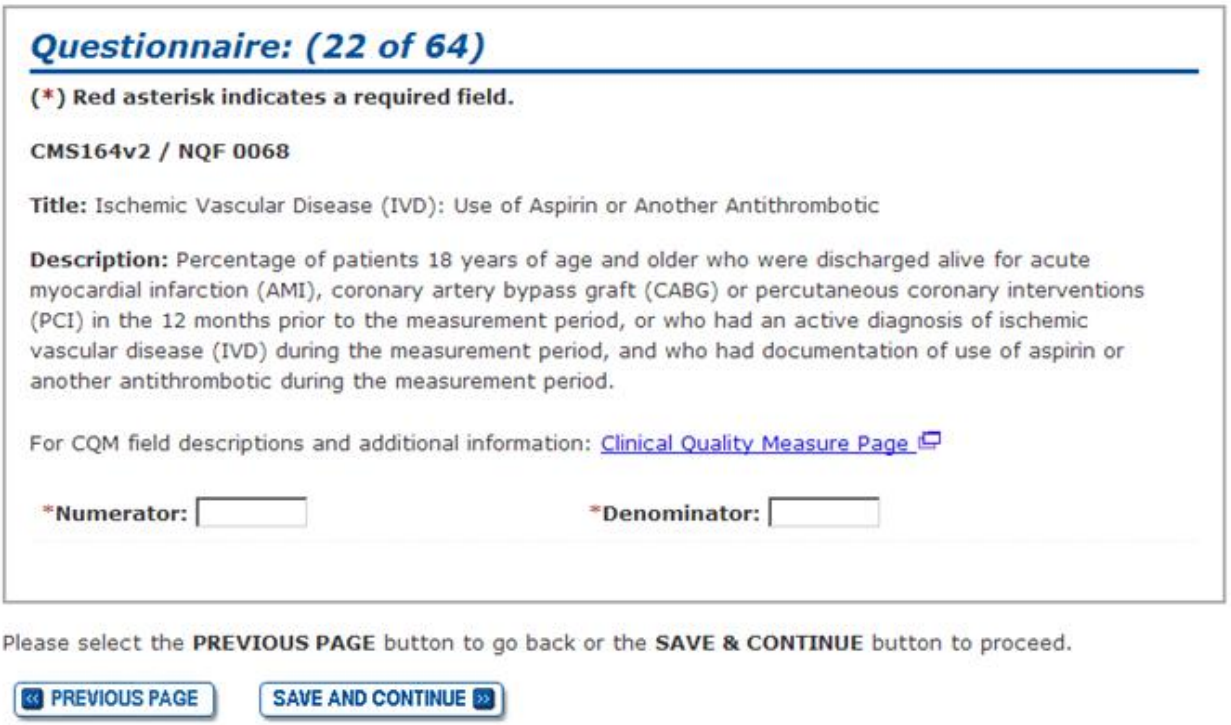


Figure 119 - CQM Question 22 IVD: Use of Aspirin or Another Antithrombotic

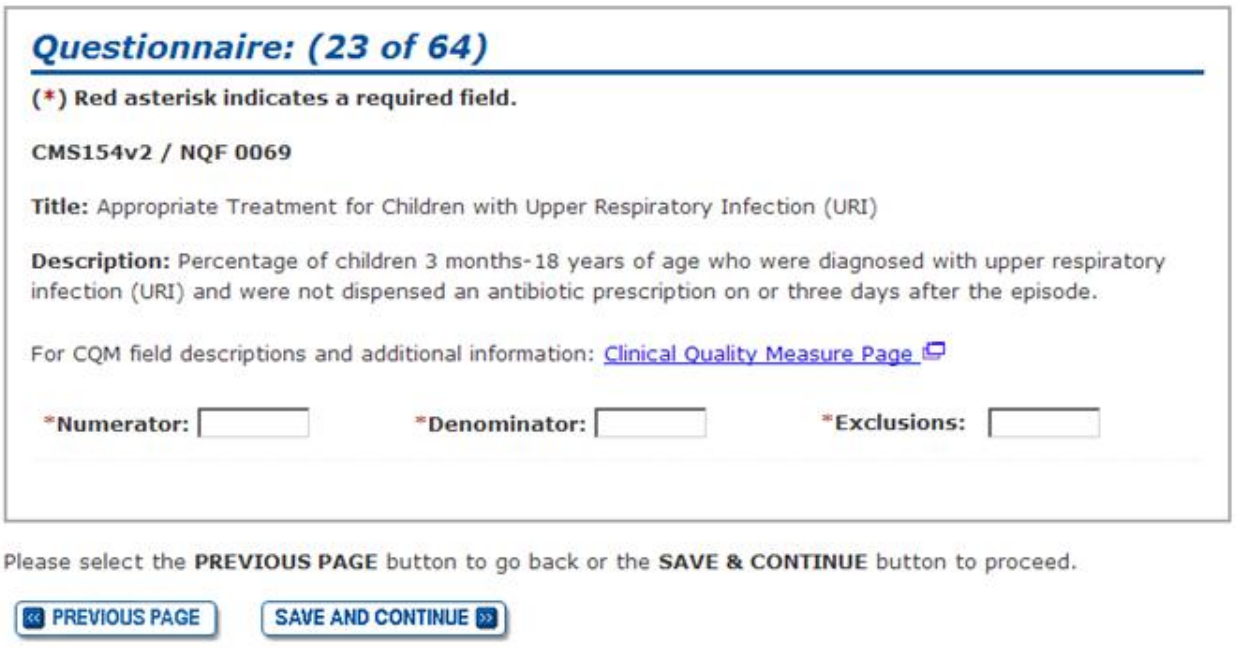


Figure 120 - CQM Question 23 Appropriate Treatment for Children with URI

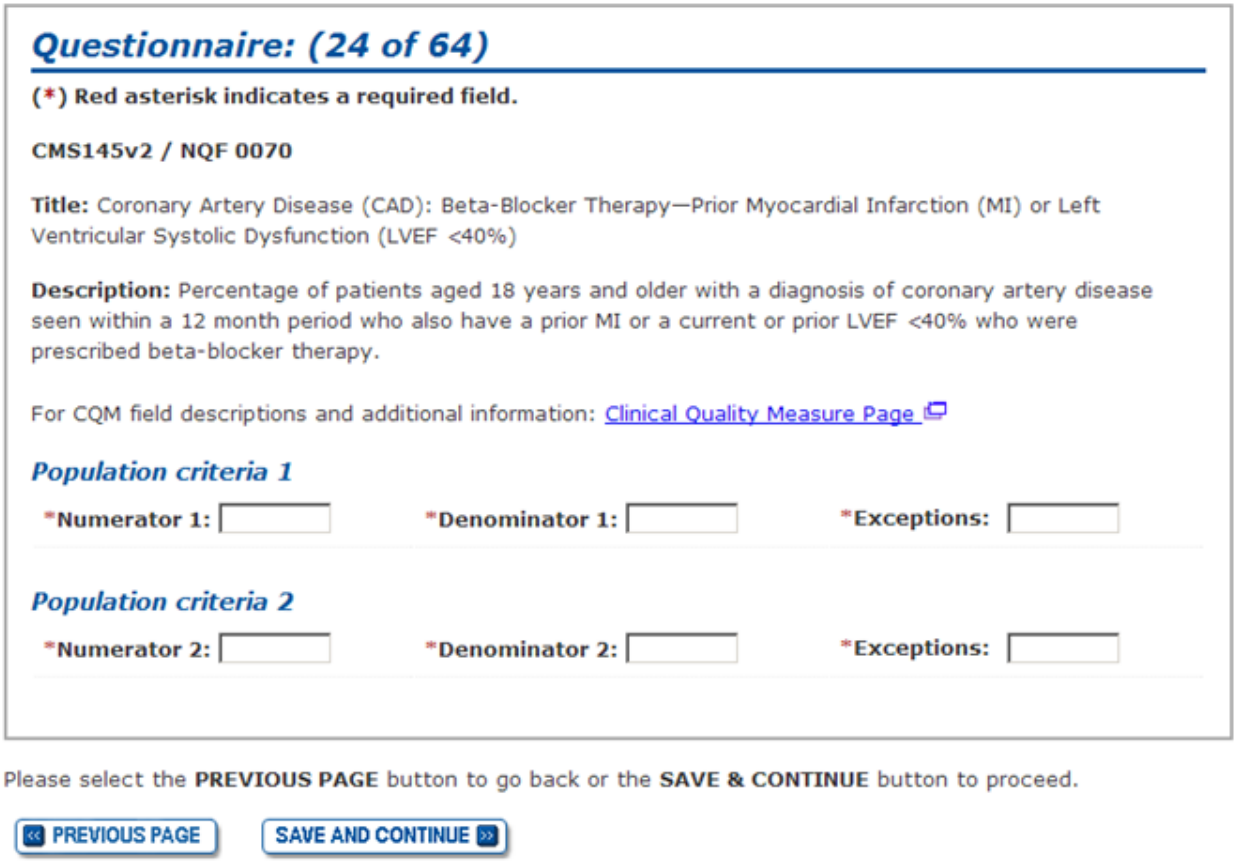


Figure 121 - CQM Question 24 CAD: Beta-Blocker Therapy - Prior MI or LVEF < 40%

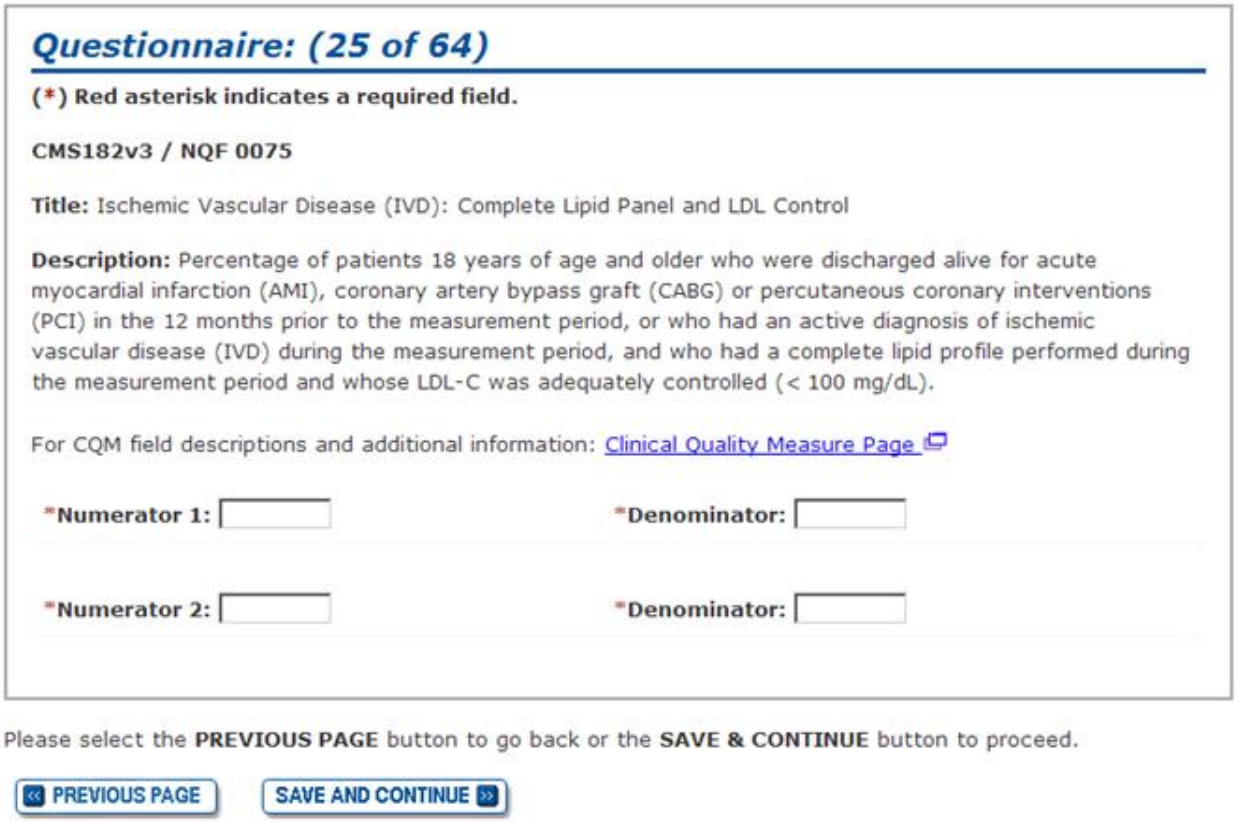


Figure 122 - CQM Question 25 IVD: Complete Lipid Panel and LDL Control

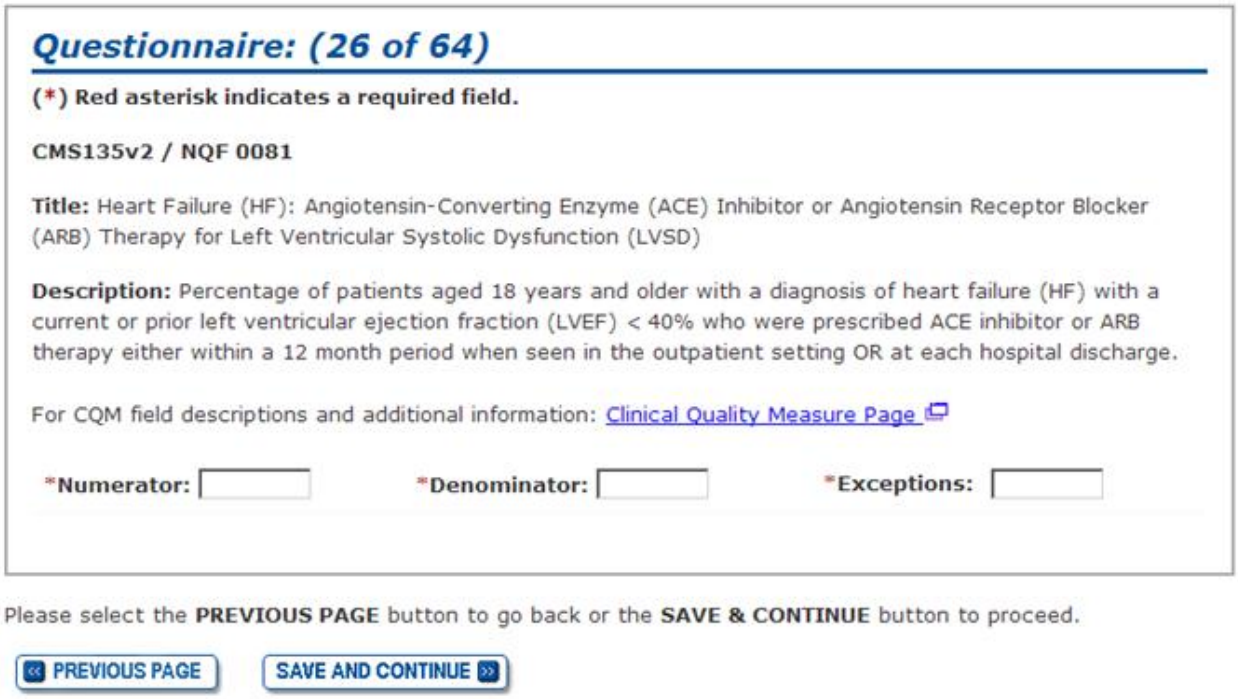


Figure 123 - CQM Question 26 HF: ACE Inhibitor or ARB Therapy for LVSD

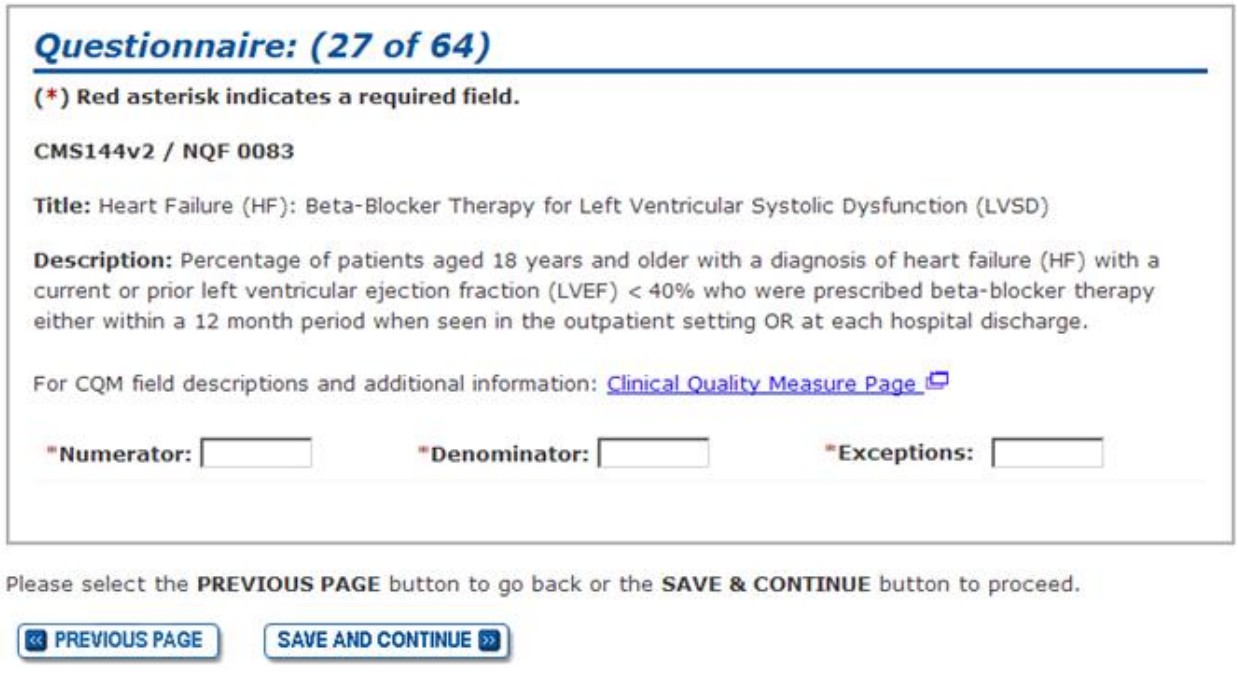


Figure 124 - CQM Question 27 HF: Beta-Blocker Therapy for LVSD

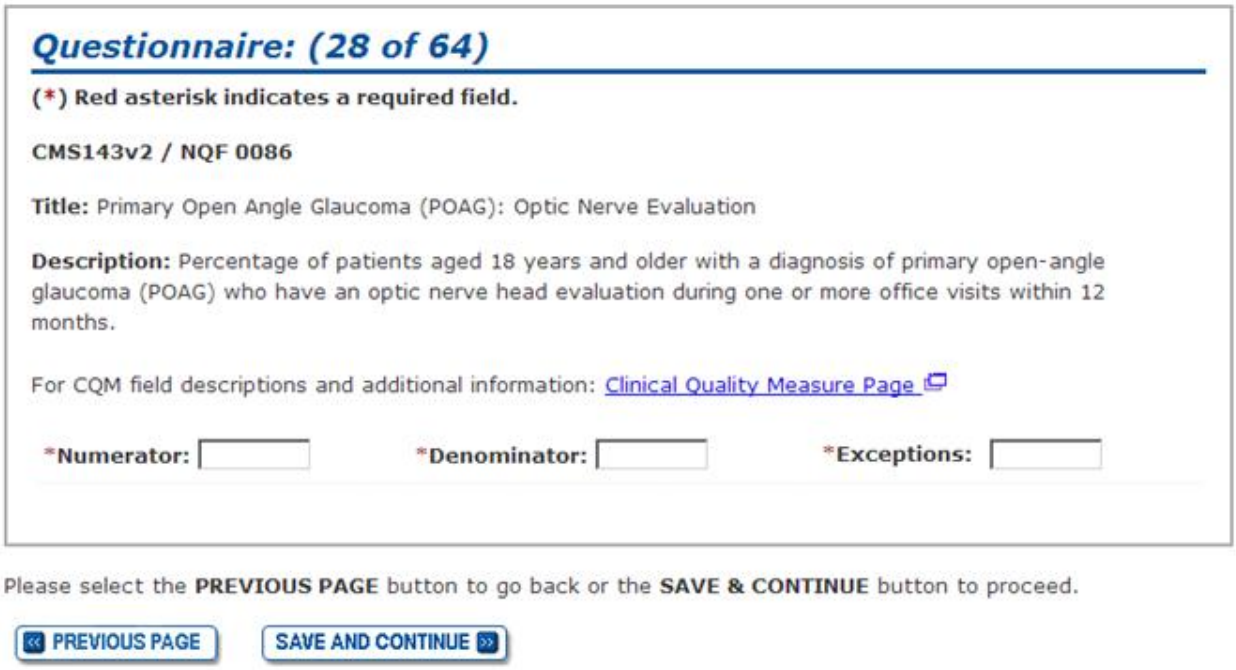


Figure 125 - CQM Question 28 POAG: Optic Nerve Evaluation

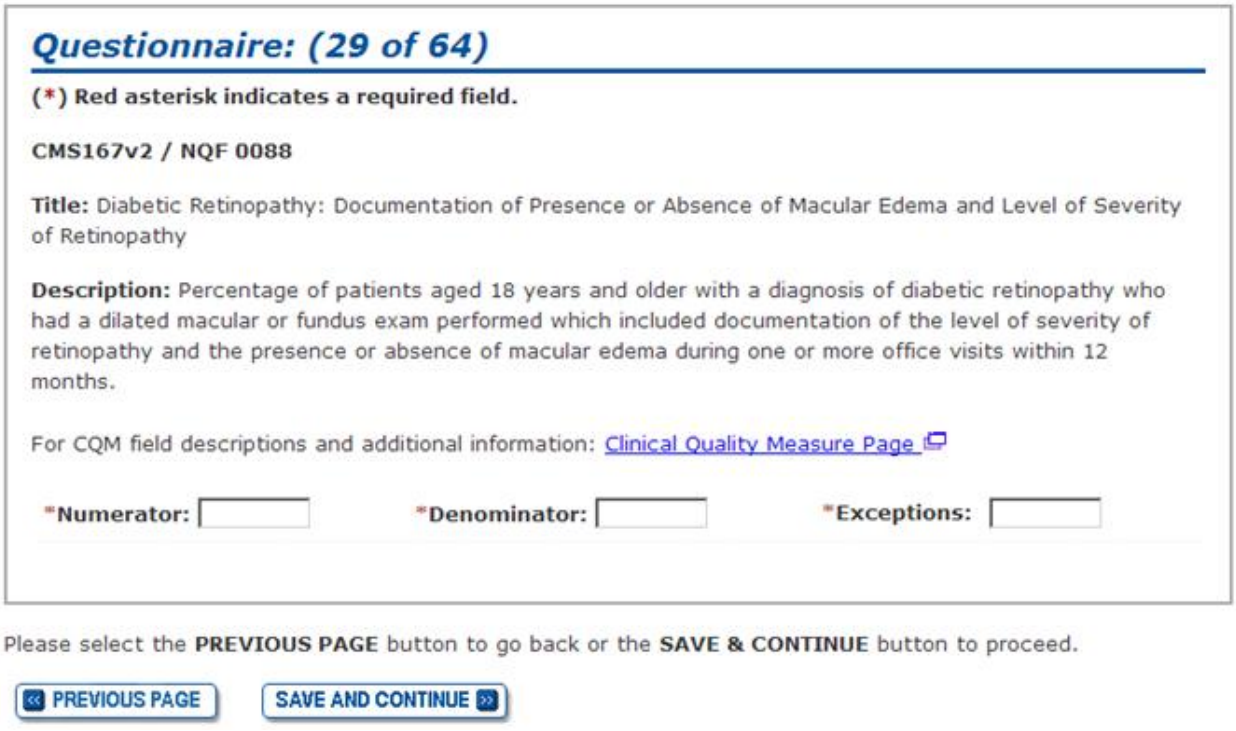


Figure 126 - CQM Question 29 Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

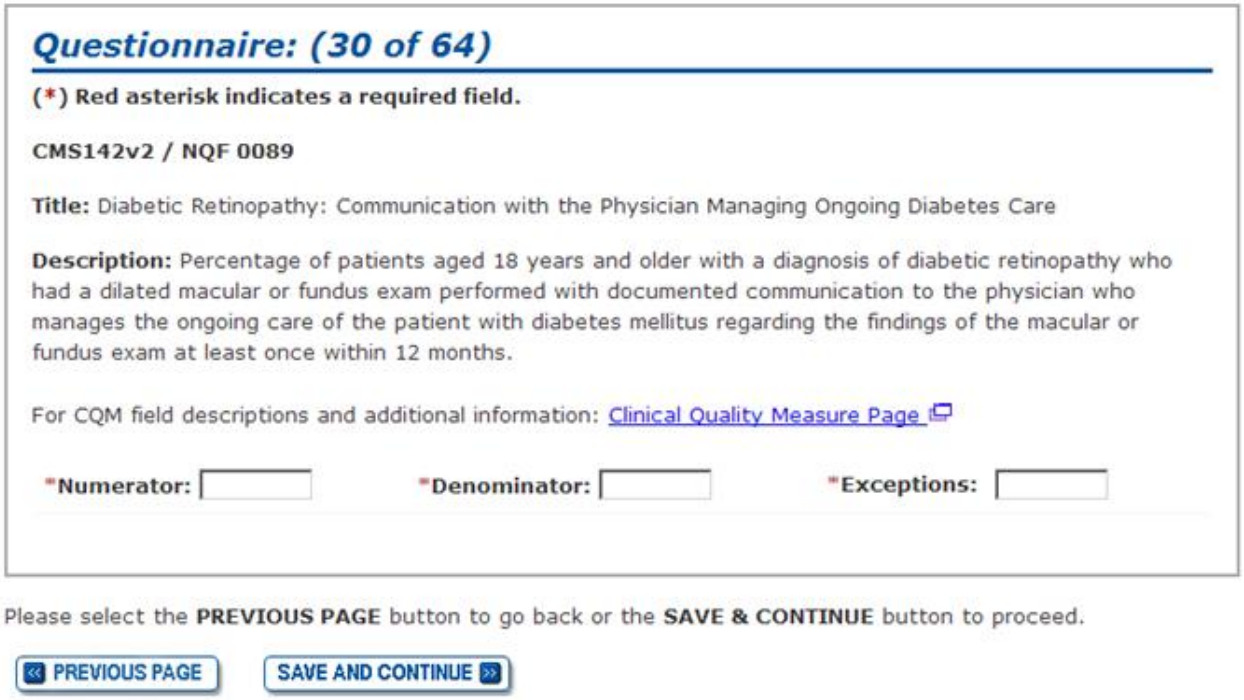


Figure 127 - CQM Question 30 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

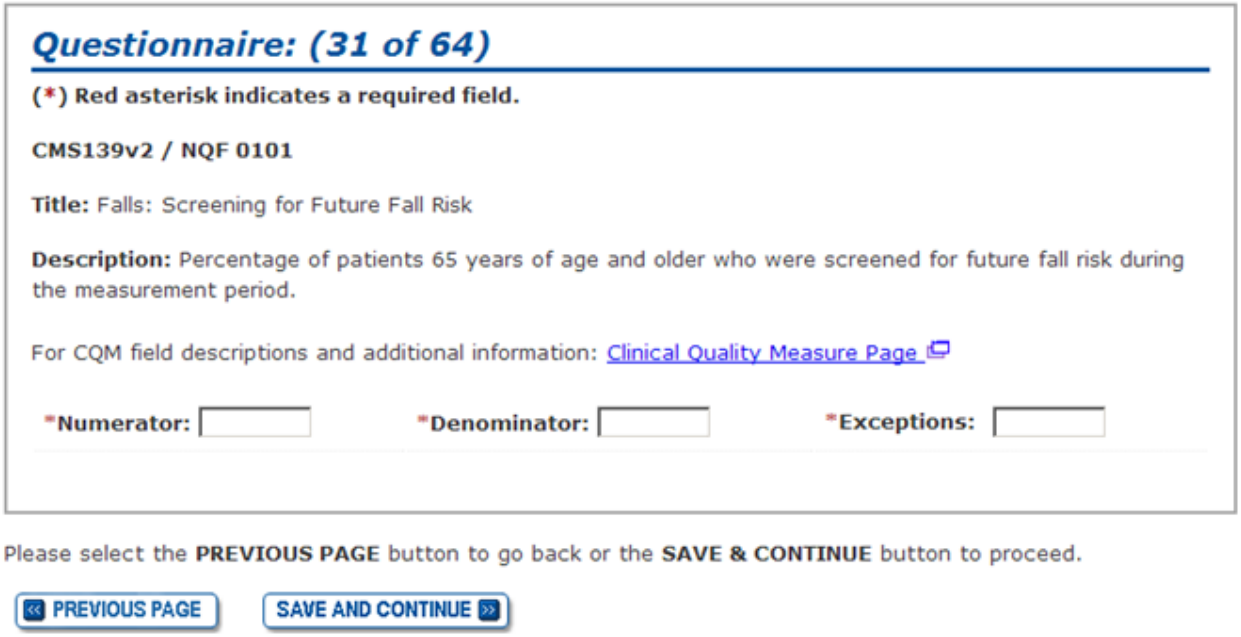


Figure 128 - CQM Question 31 Falls: Screening for Future Fall Risk

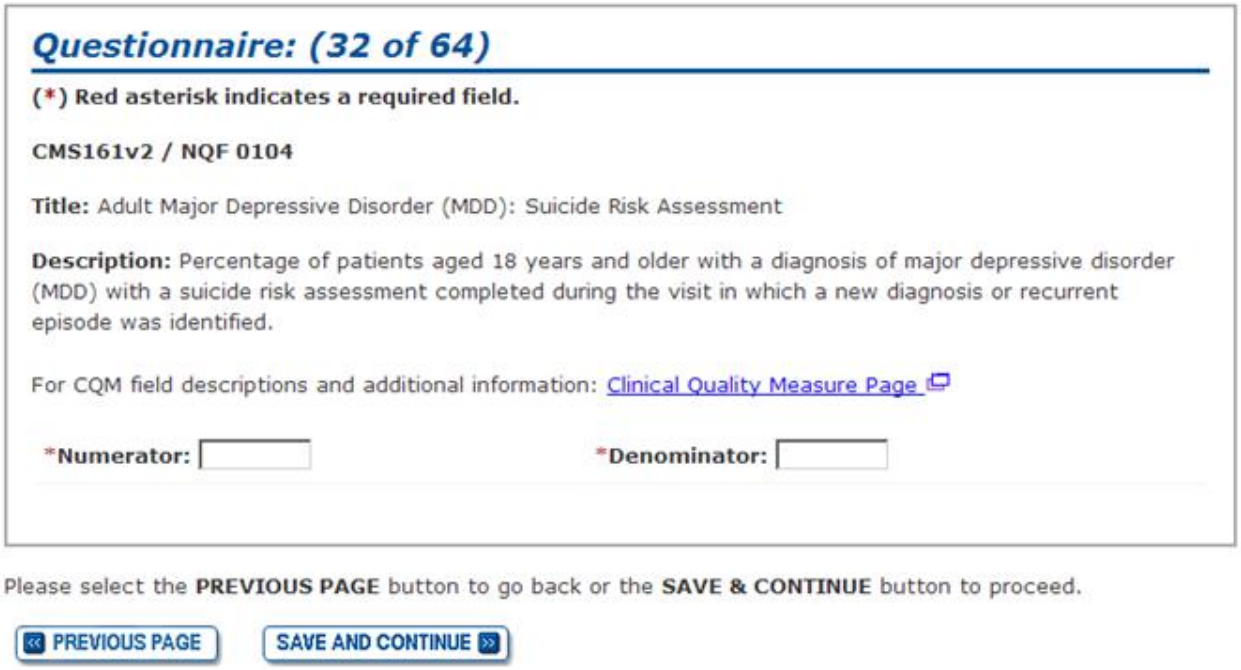


Figure 129 - CQM Question 32 MDD: Suicide Risk Assessment

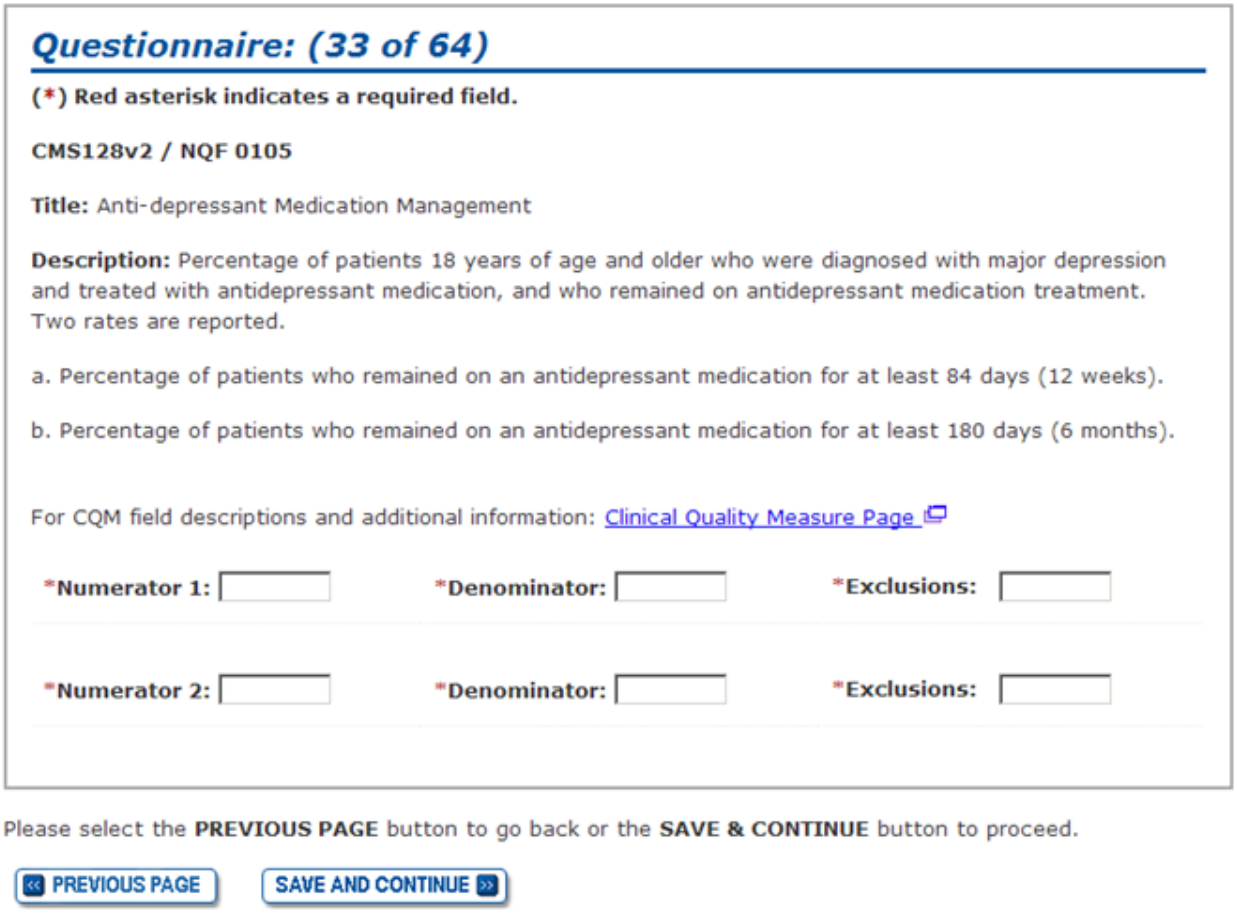


Figure 130 - CQM Question 33 Anti-depressant Medication Management

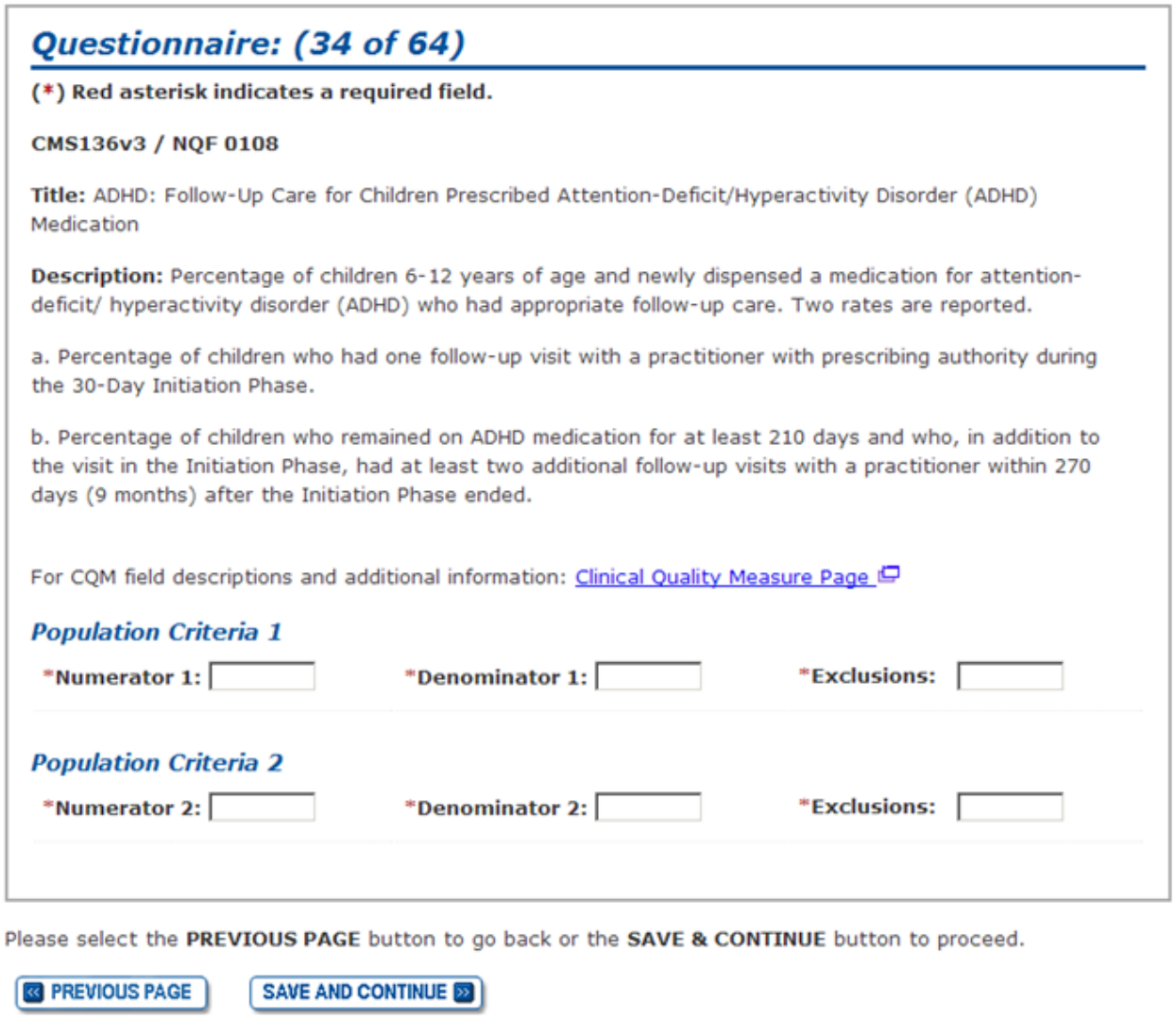


Figure 131 - CQM Question 34 ADHD: Follow-up Care for Children Prescribed ADHD Medication

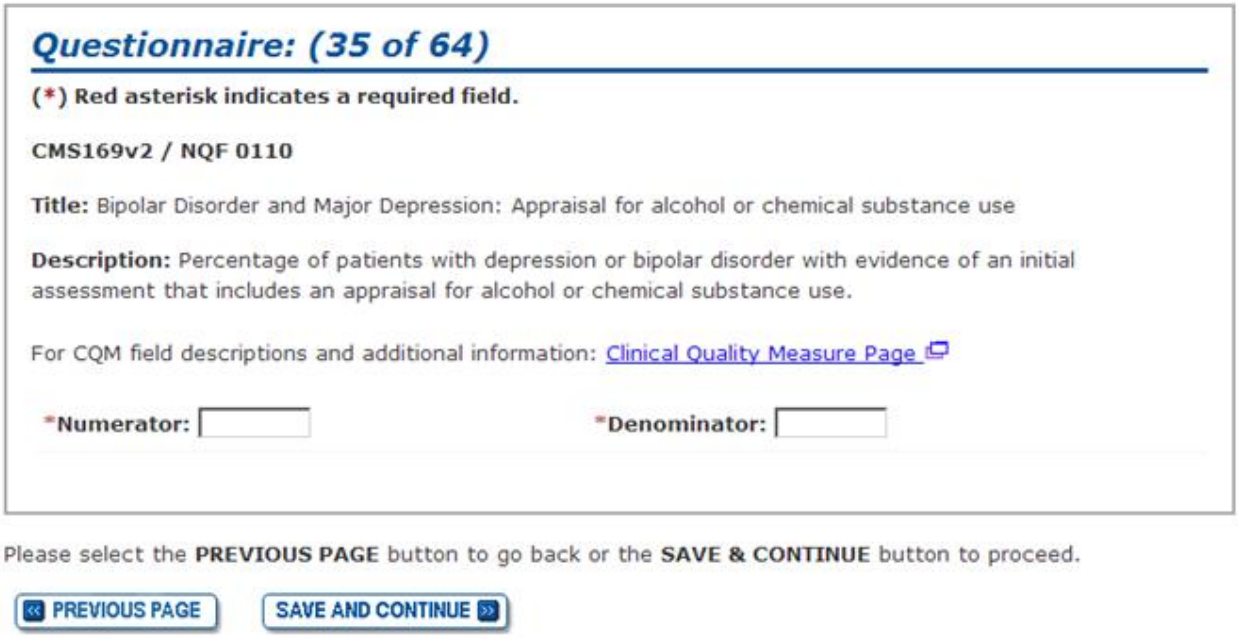


Figure 132 - Question 35 Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use

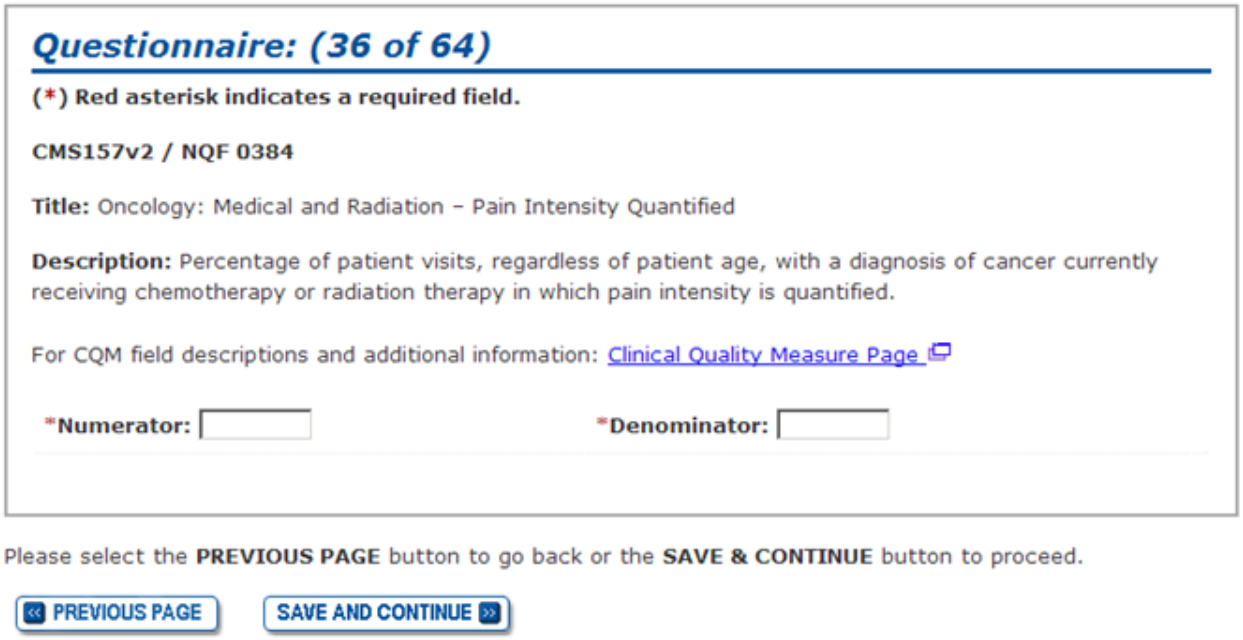


Figure 133 - CQM Question 36 Oncology: Medical and Radiation - Pain Intensity Quantified

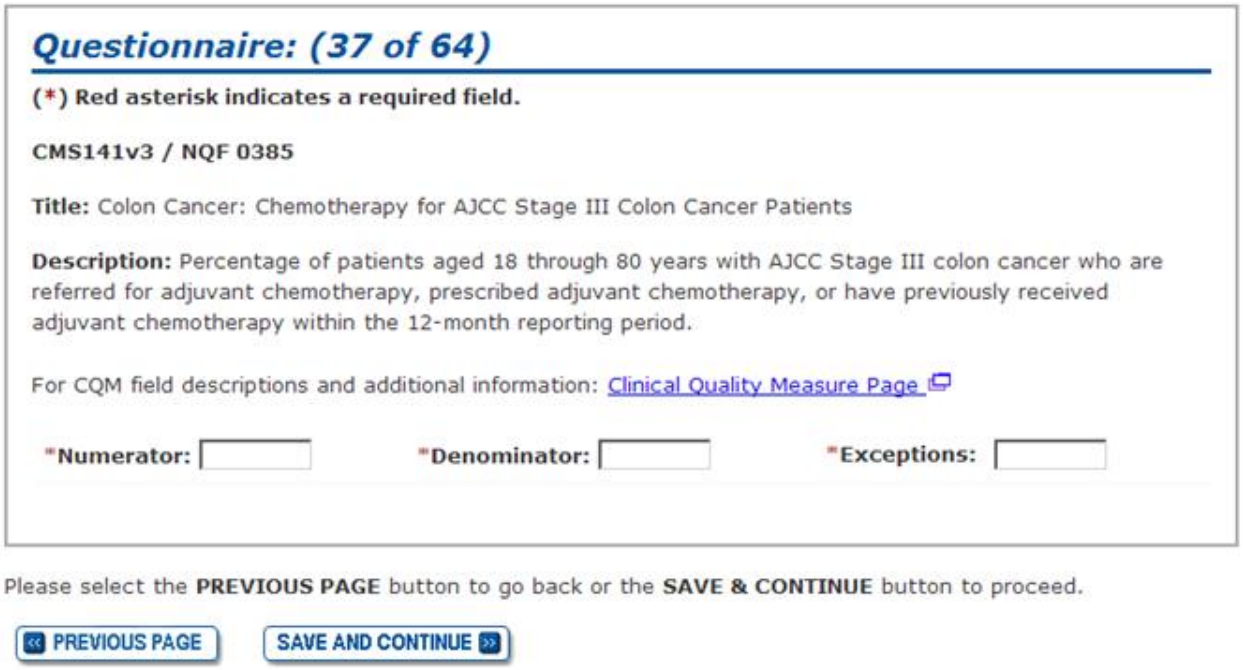


Figure 134 - CQM Question 37 Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients

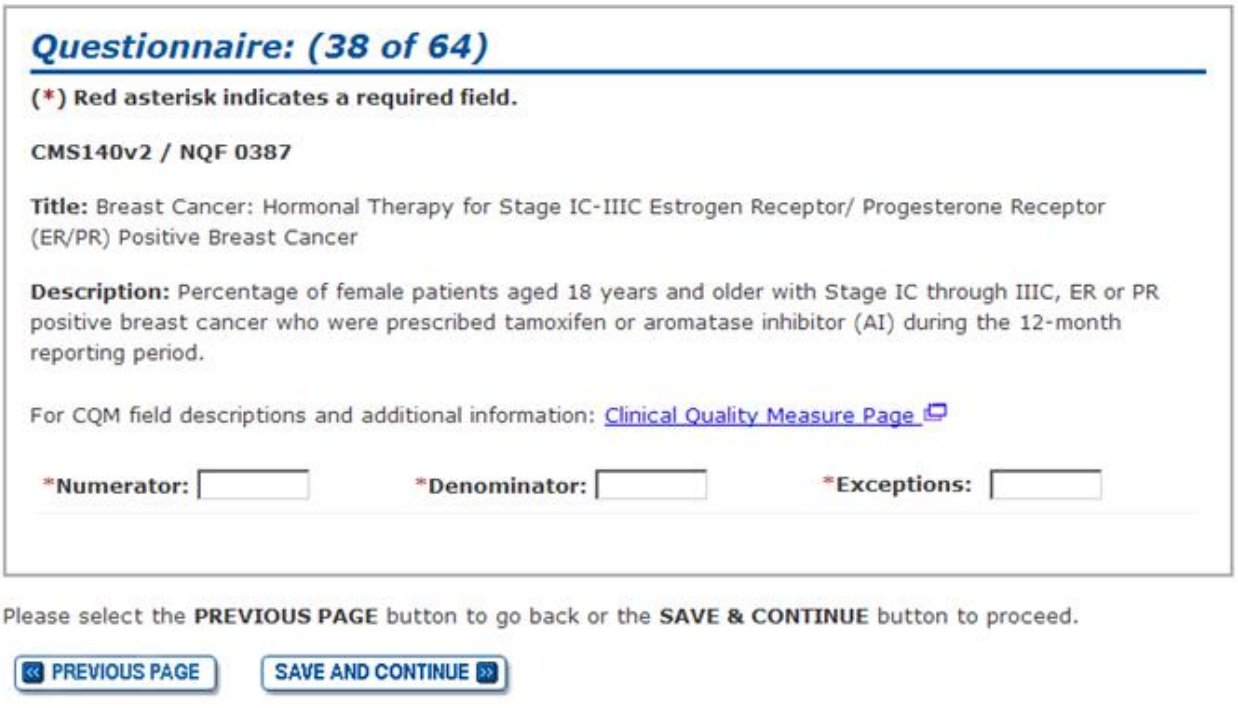


Figure 135 - CQM Question 38 - Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen receptor/Progesterone Receptor Positive Breast Cancer

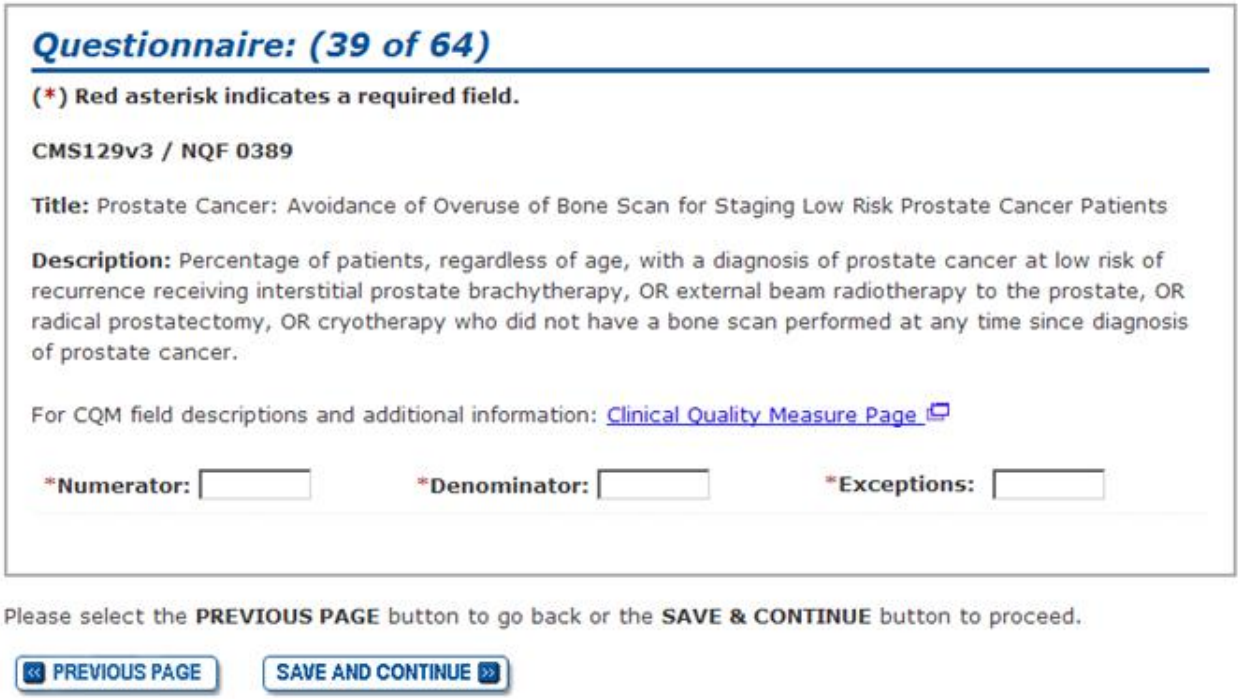


Figure 136 - CQM Question 39 Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

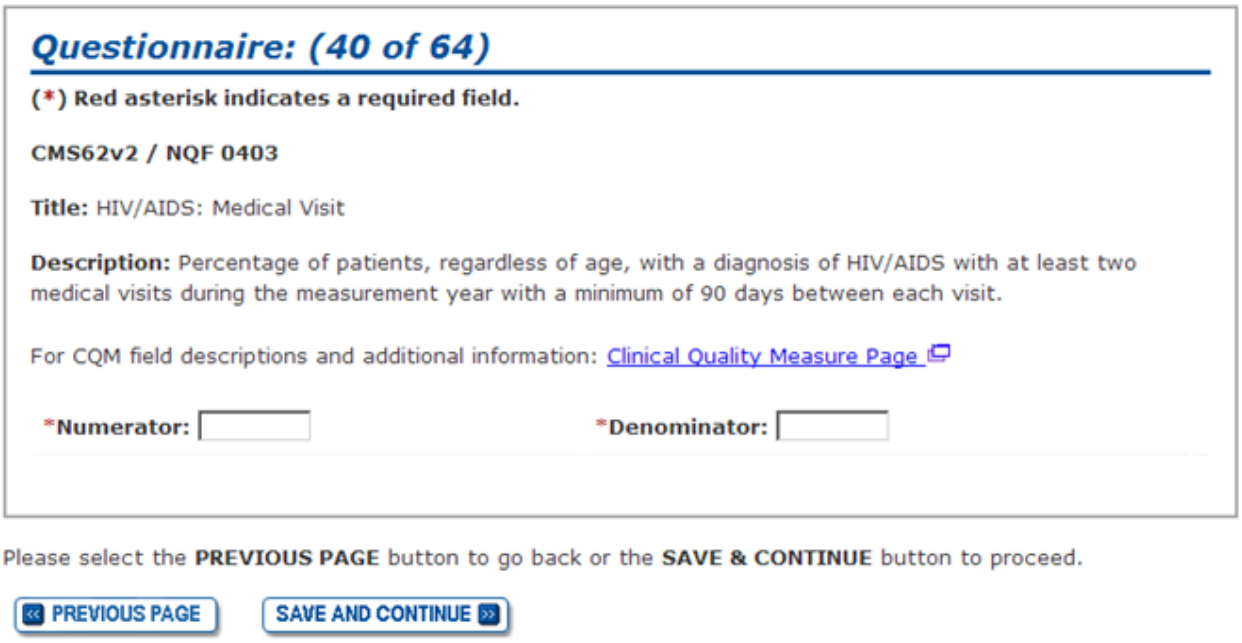


Figure 137 - CQM Question 40 HIV/AIDS: Medical Visit

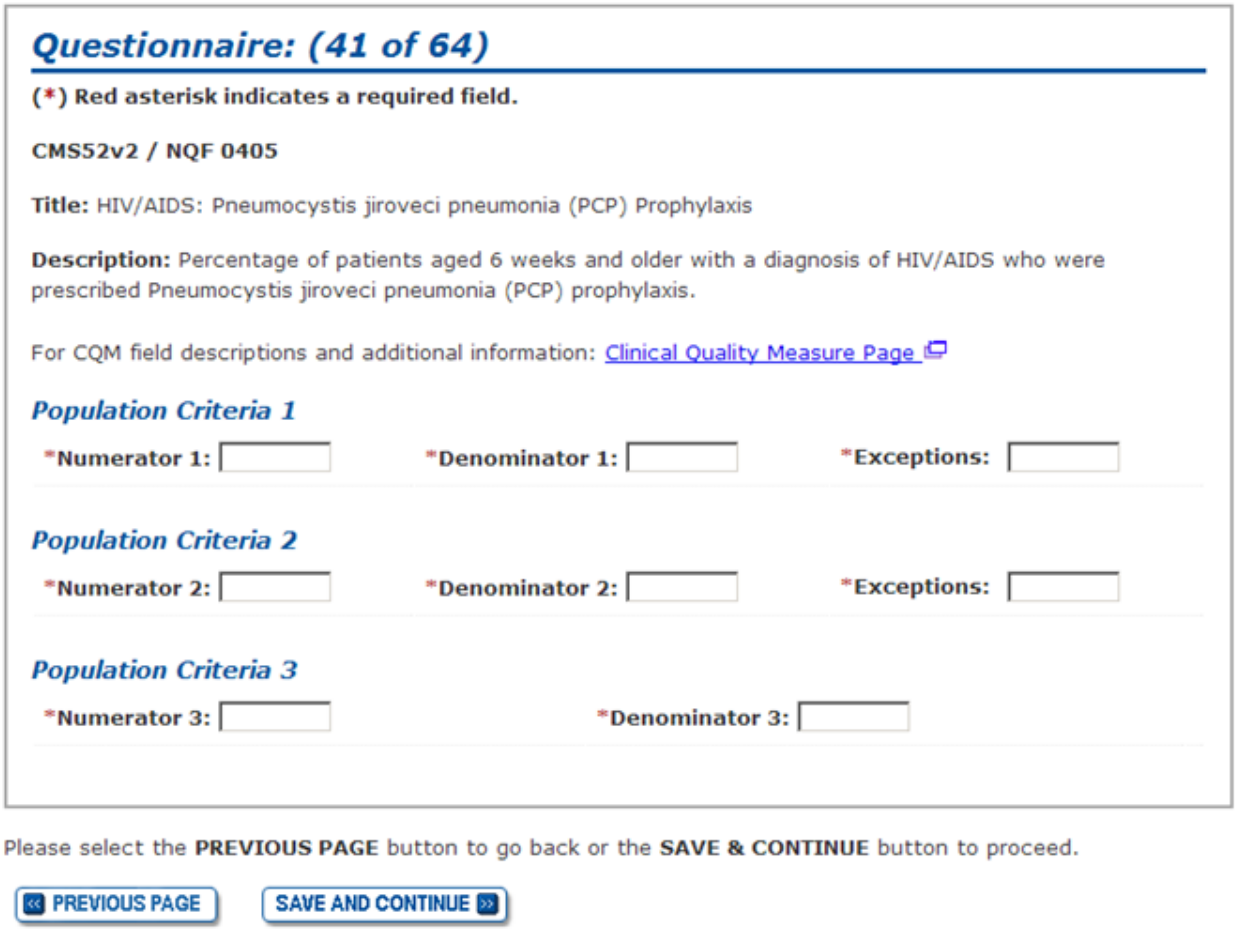


Figure 138 - CQM Question 41 HIV/AIDS: PCP Prophylaxis

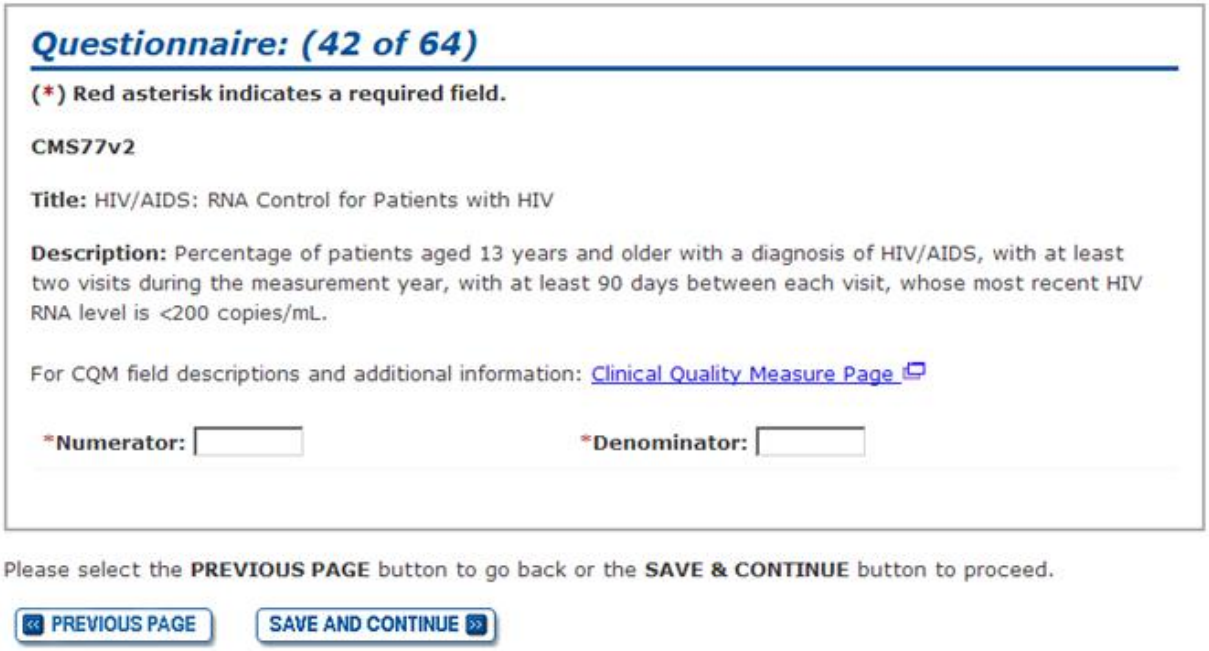


Figure 139 - CQM Question 42 HIV/AIDS: RNA Control for Patients with HIV

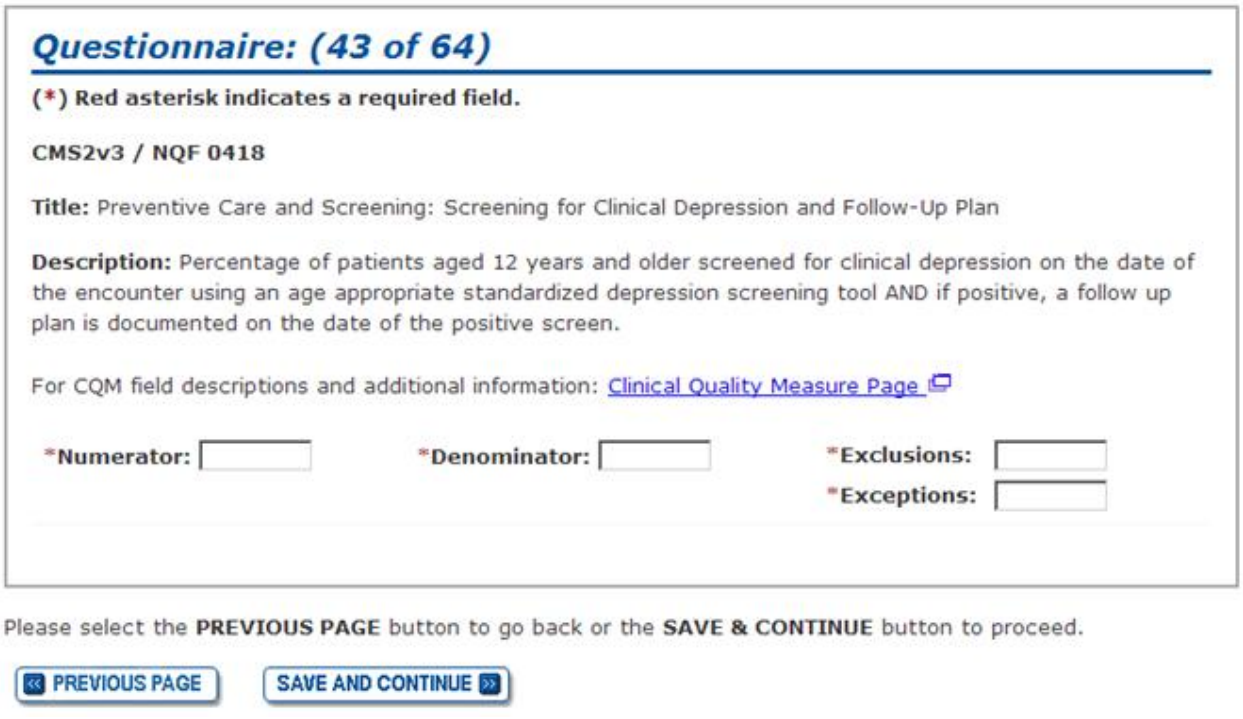


Figure 140 - CQM Question 43 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

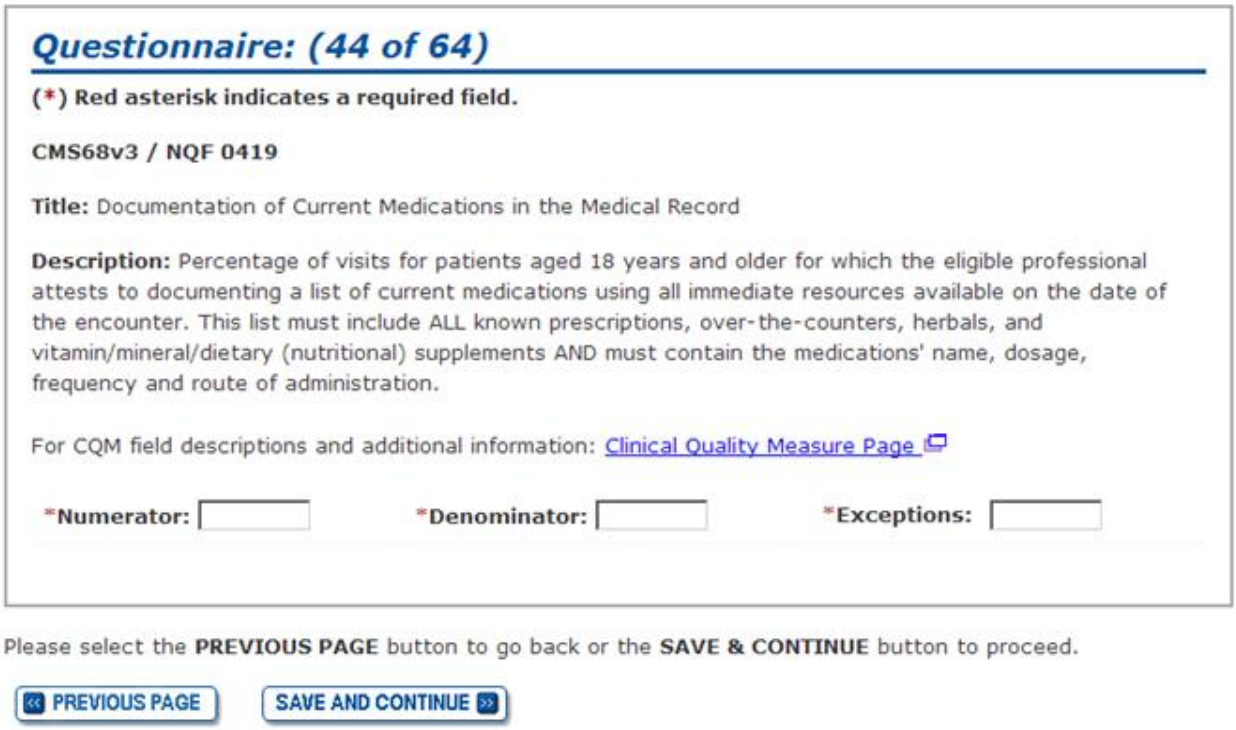


Figure 141 - CQM Question 44 Documentation of Current Medications in the Medical Record

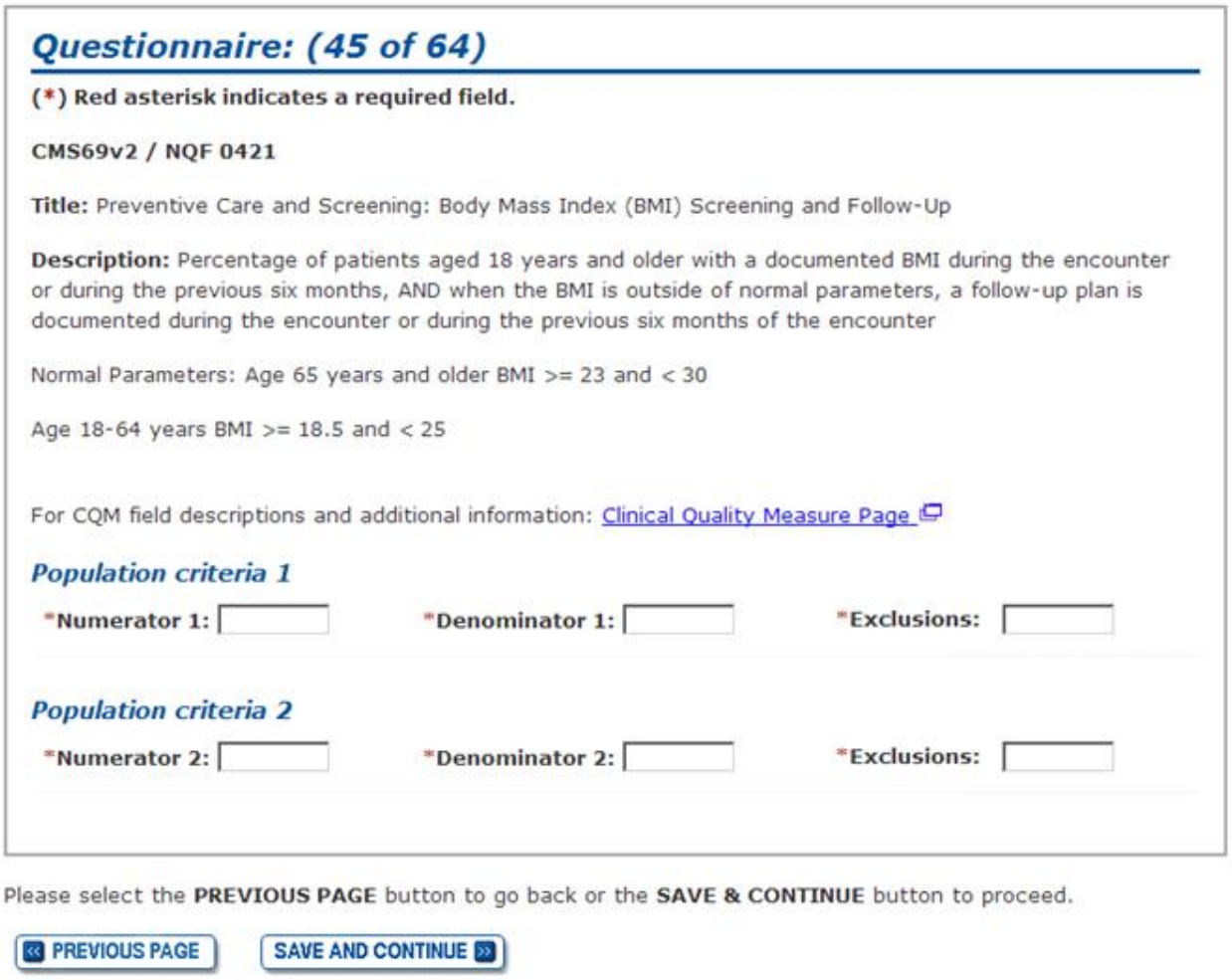


Figure 142 - CQM Question 45 Preventive Care and Screening: BMI Screening and Follow-up

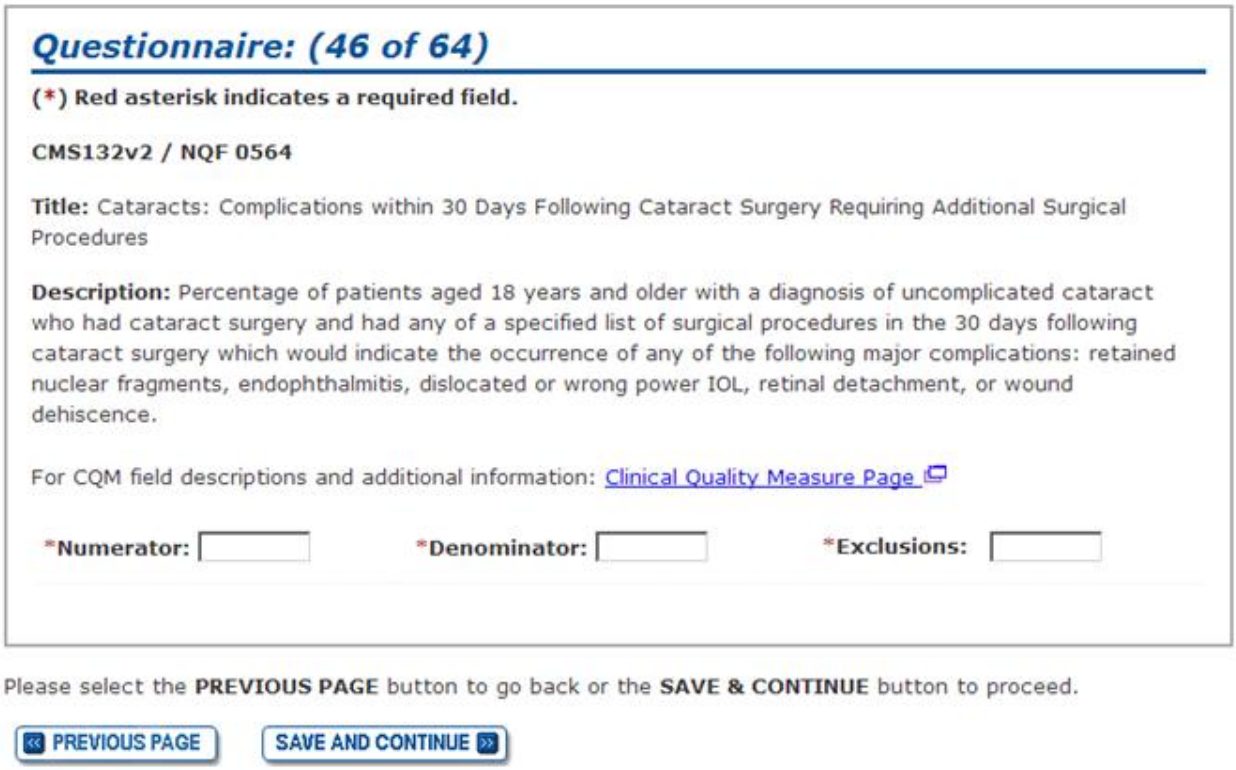


Figure 143 - CQM Question 46 Cataracts: Complications within 30 days Following Cataract Surgery Requiring Additional Surgical Procedures

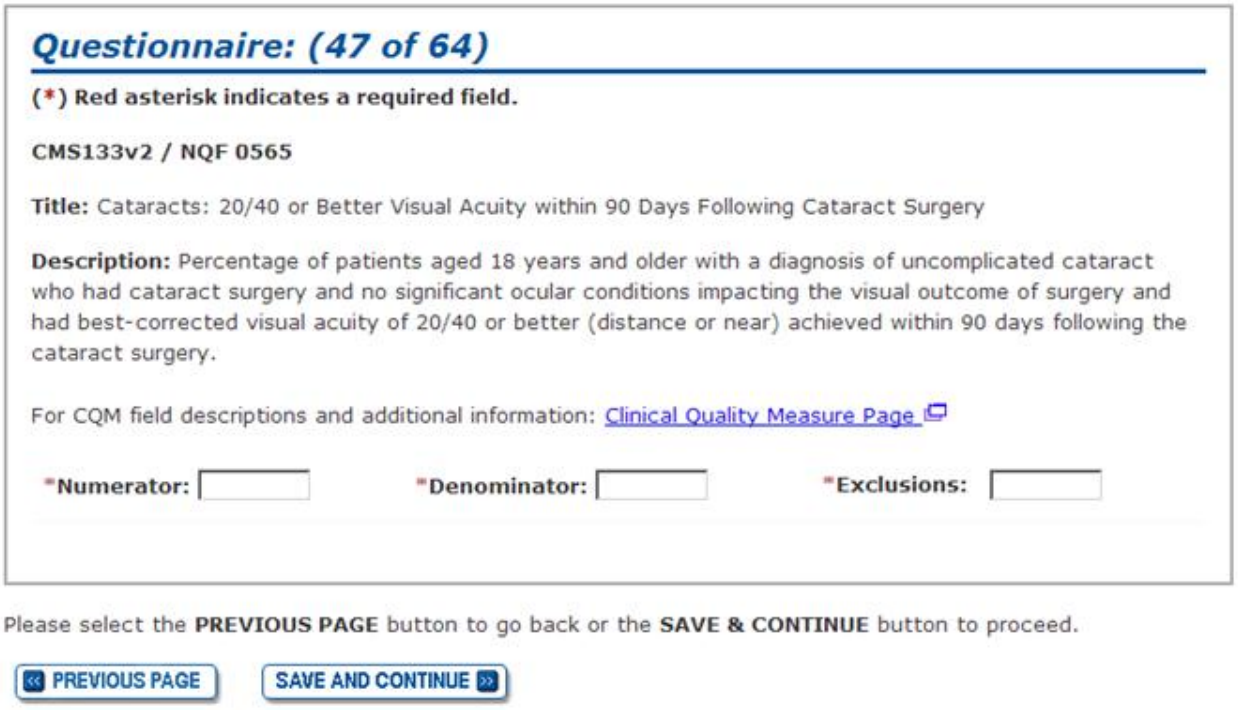


Figure 144 - CQM Question 47 Cataracts: 20/40 or Better Visual Acuity within 90 days following Cataract Surgery

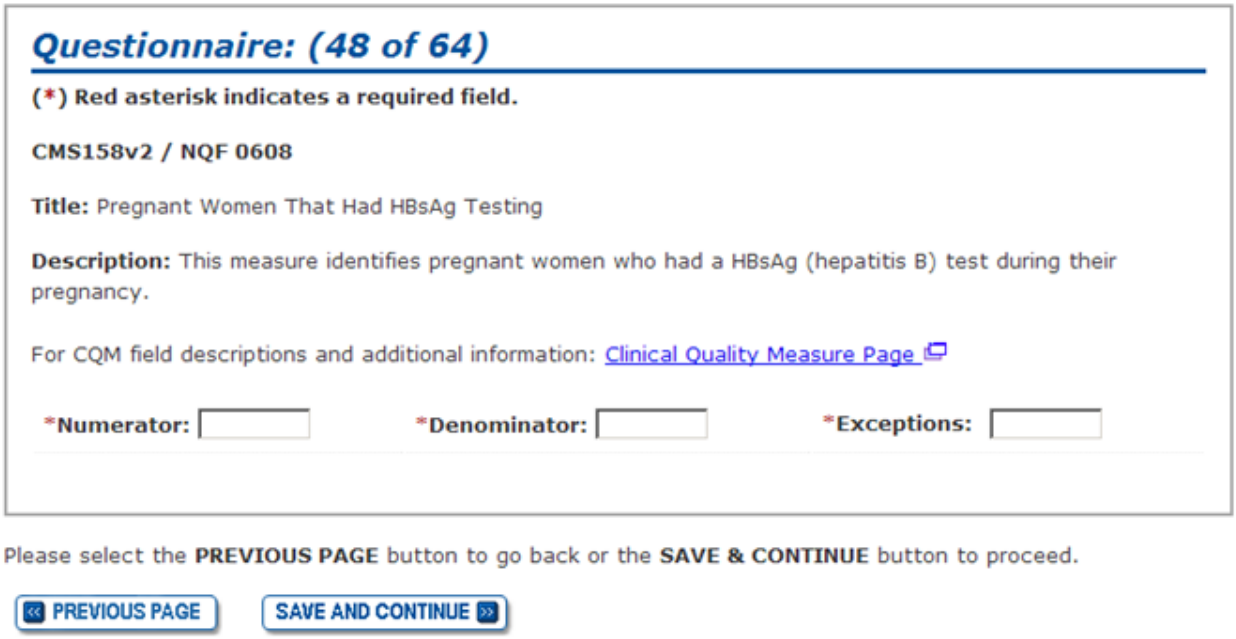


Figure 145 - CQM Question 48 Pregnant Women That had HBsAg Testing

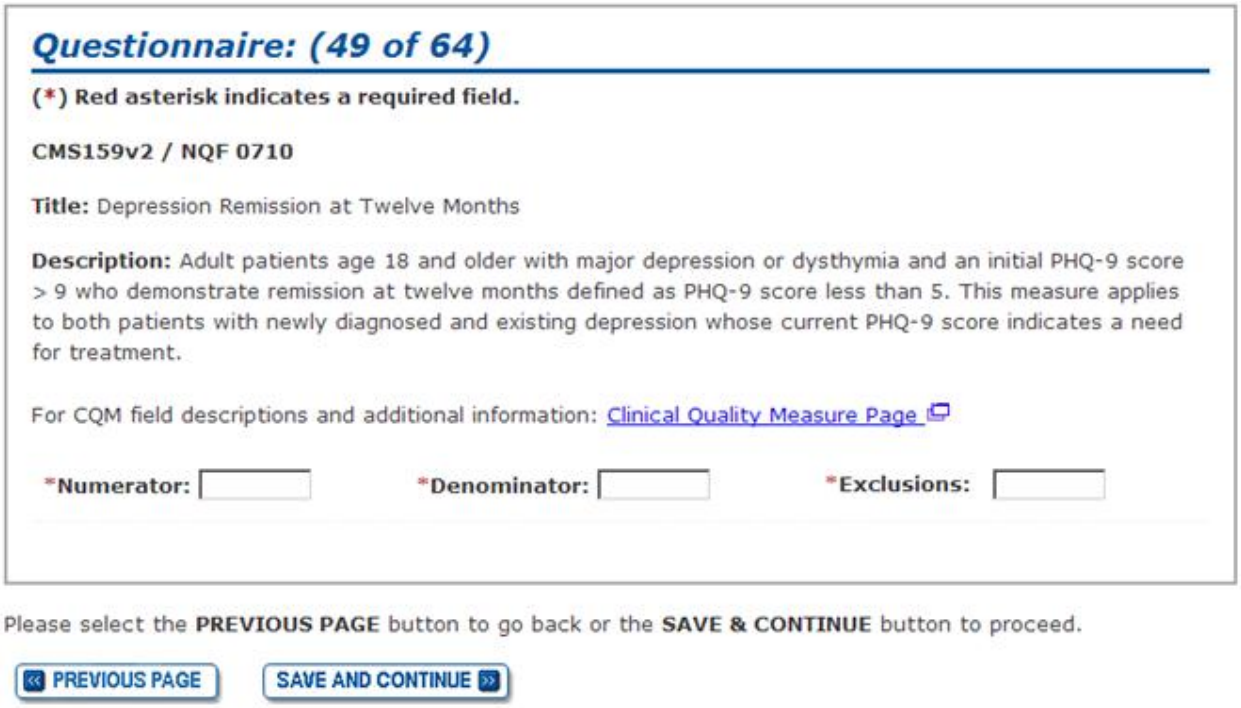


Figure 146 - CQM Question 49 Depression Remission at Twelve Months

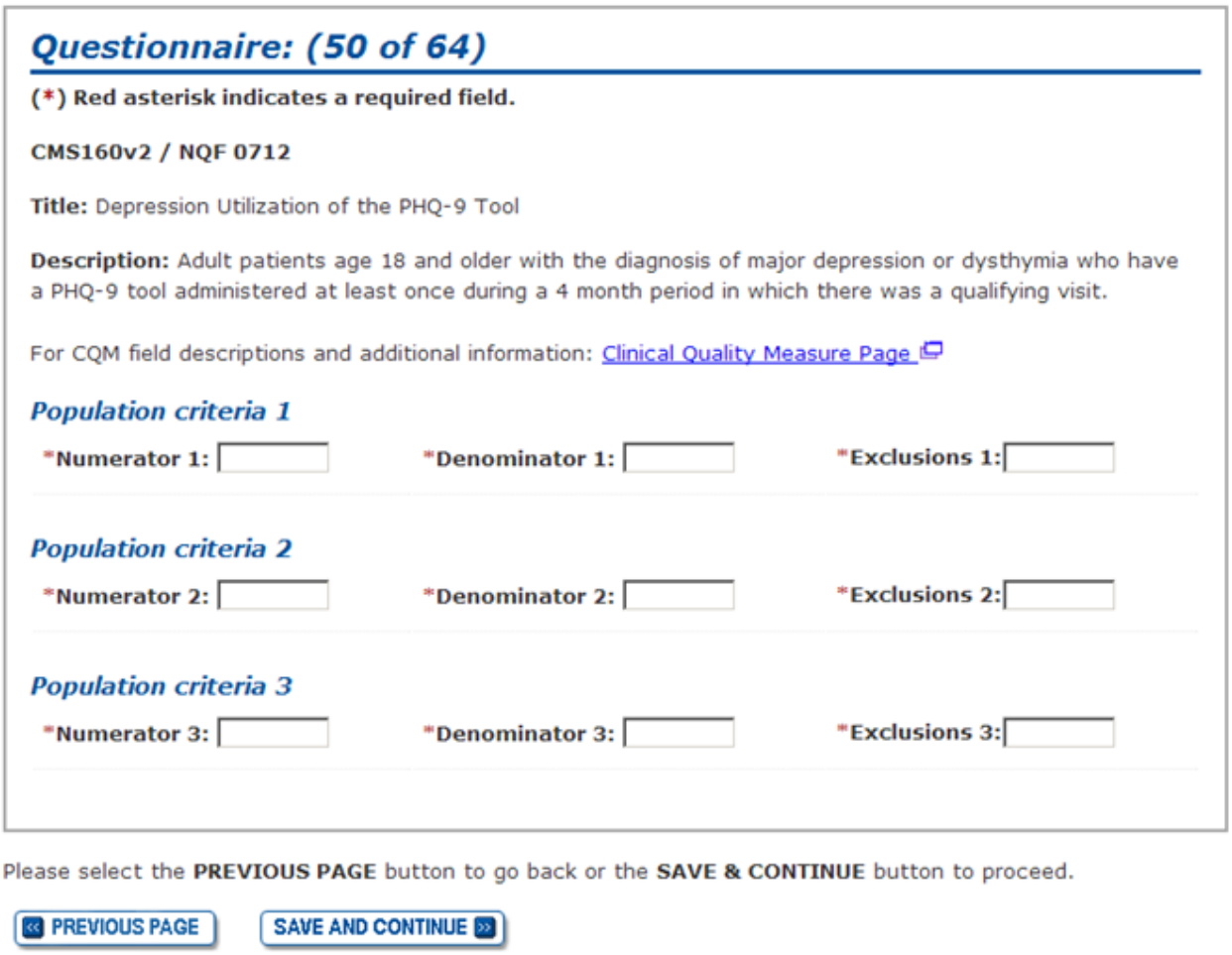


Figure 147 - CQM Question 50 Depression Utilization of the PHQ-9 Tool

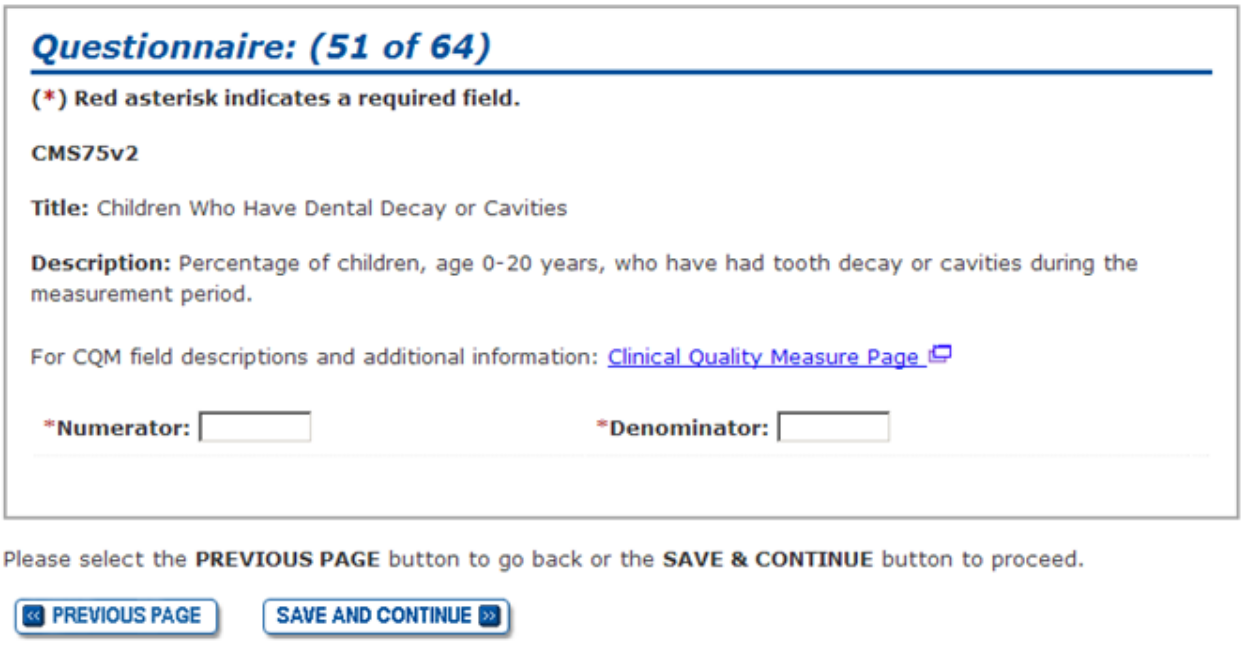


Figure 148 - CQM Question 51 Children Who have Dental Decay or Cavities

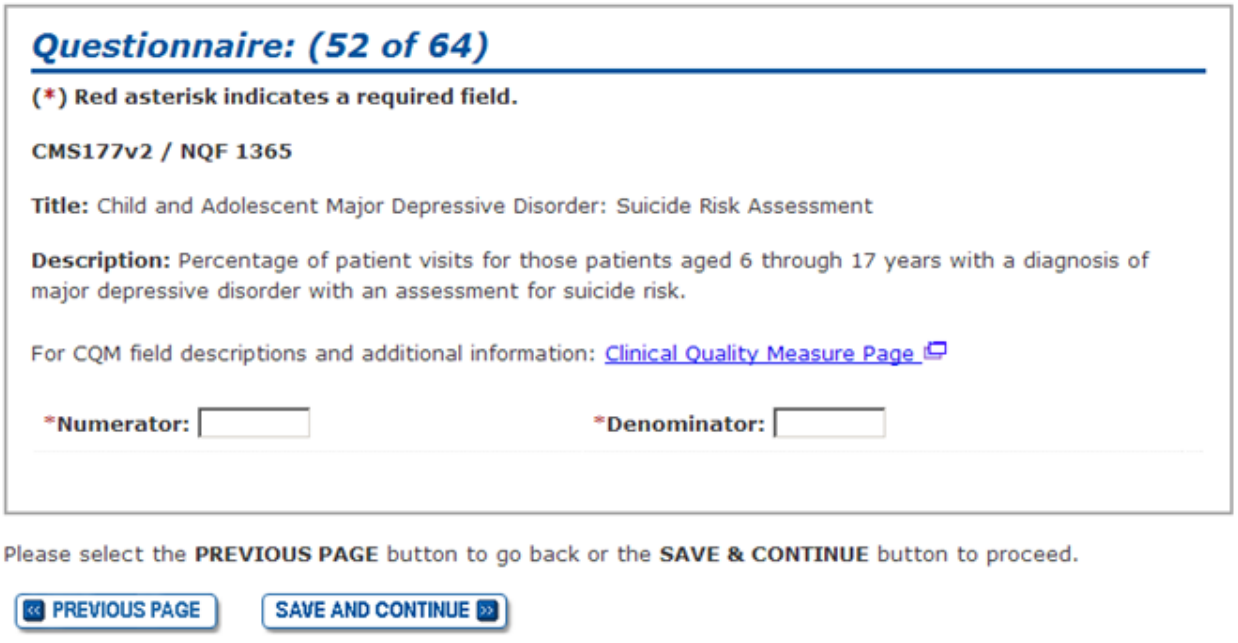


Figure 149 - CQM Question 52 Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment

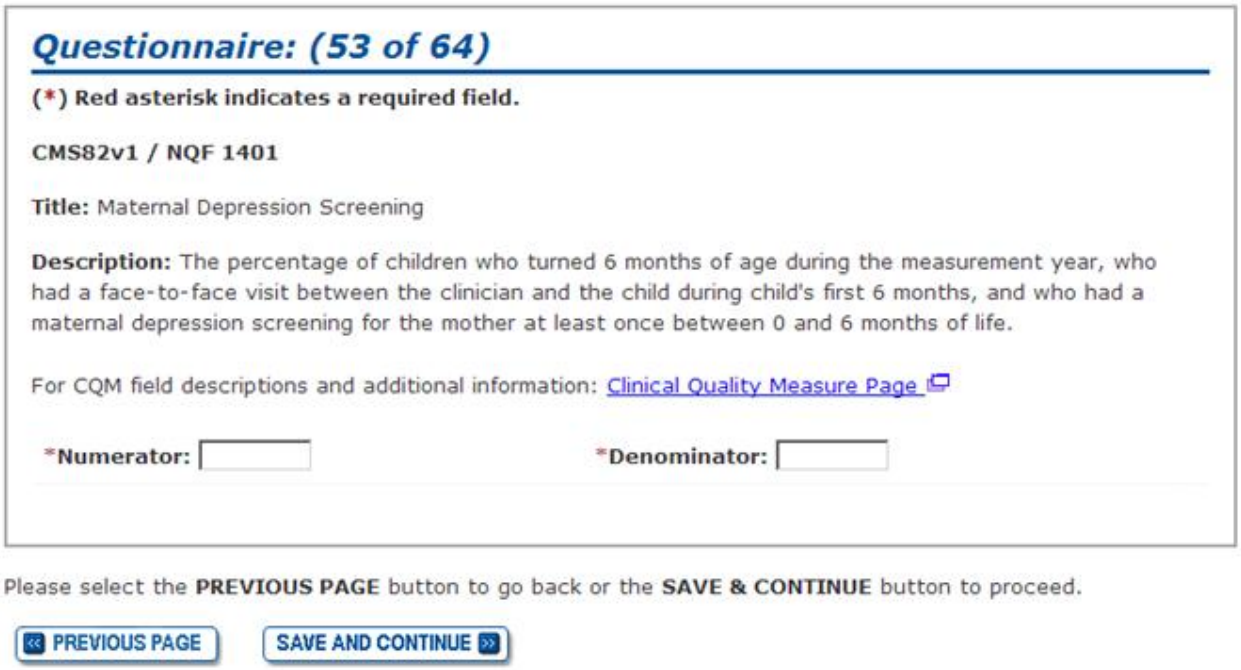


Figure 150 - CQM Question 53 Maternal Depression Screening

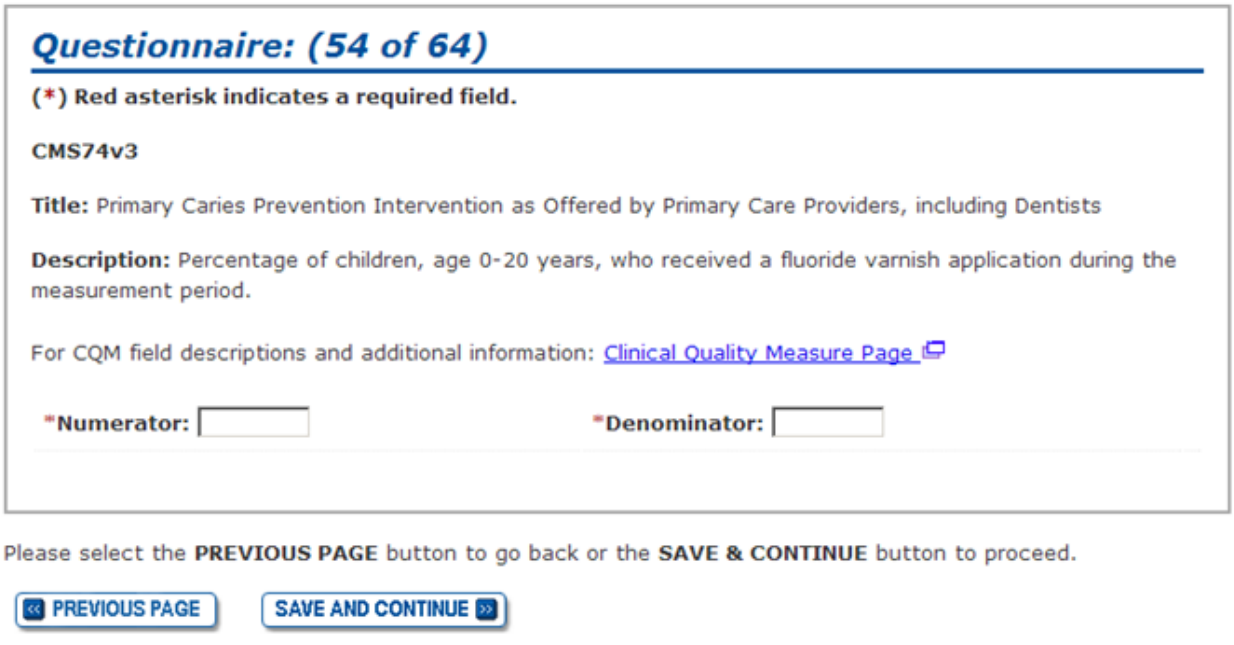


Figure 151 - CQM Question 54 Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists

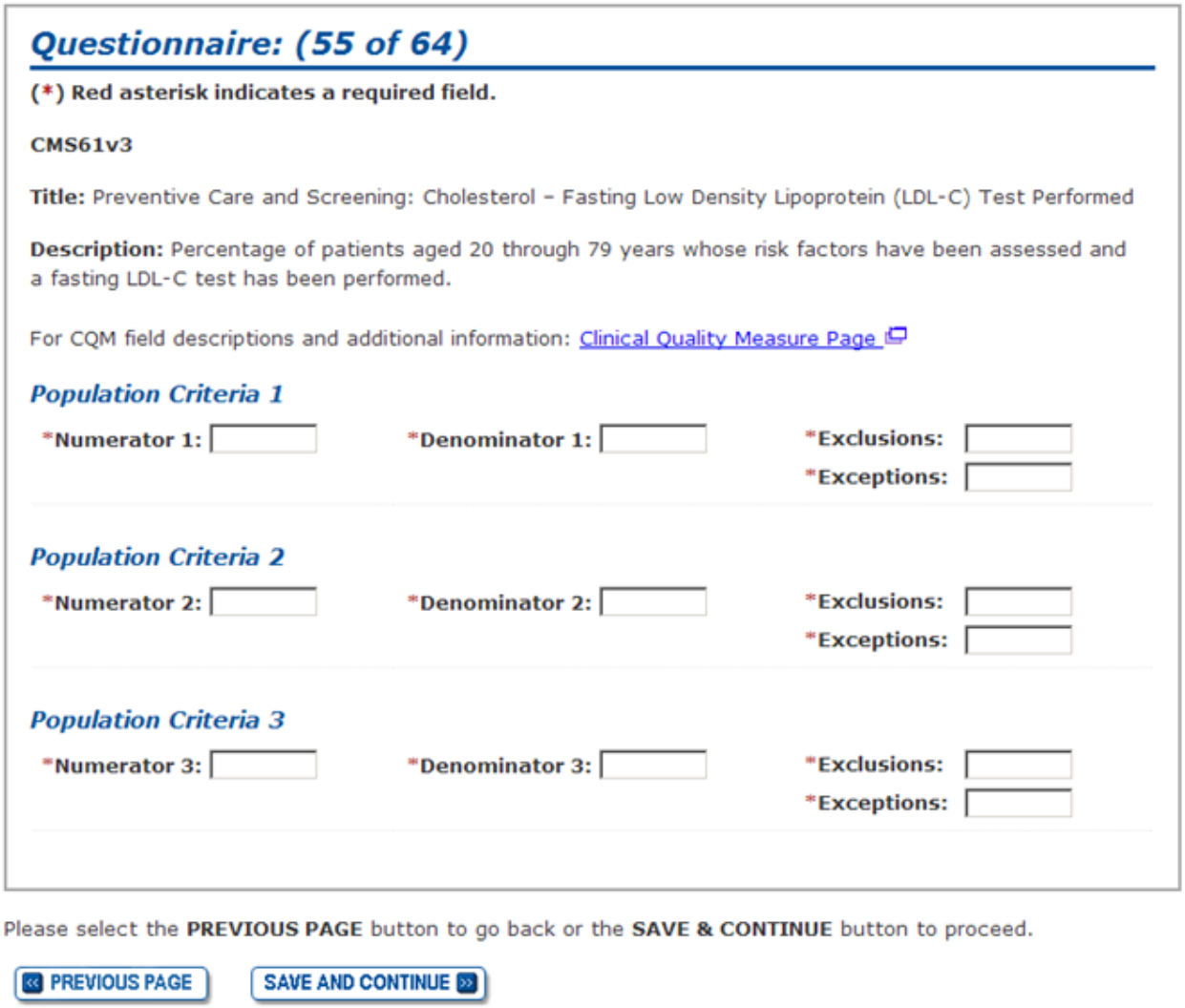


Figure 152 - CQM Question 55 Preventive Care and Screening: Cholesterol - Fasting LDL-C Test Performed

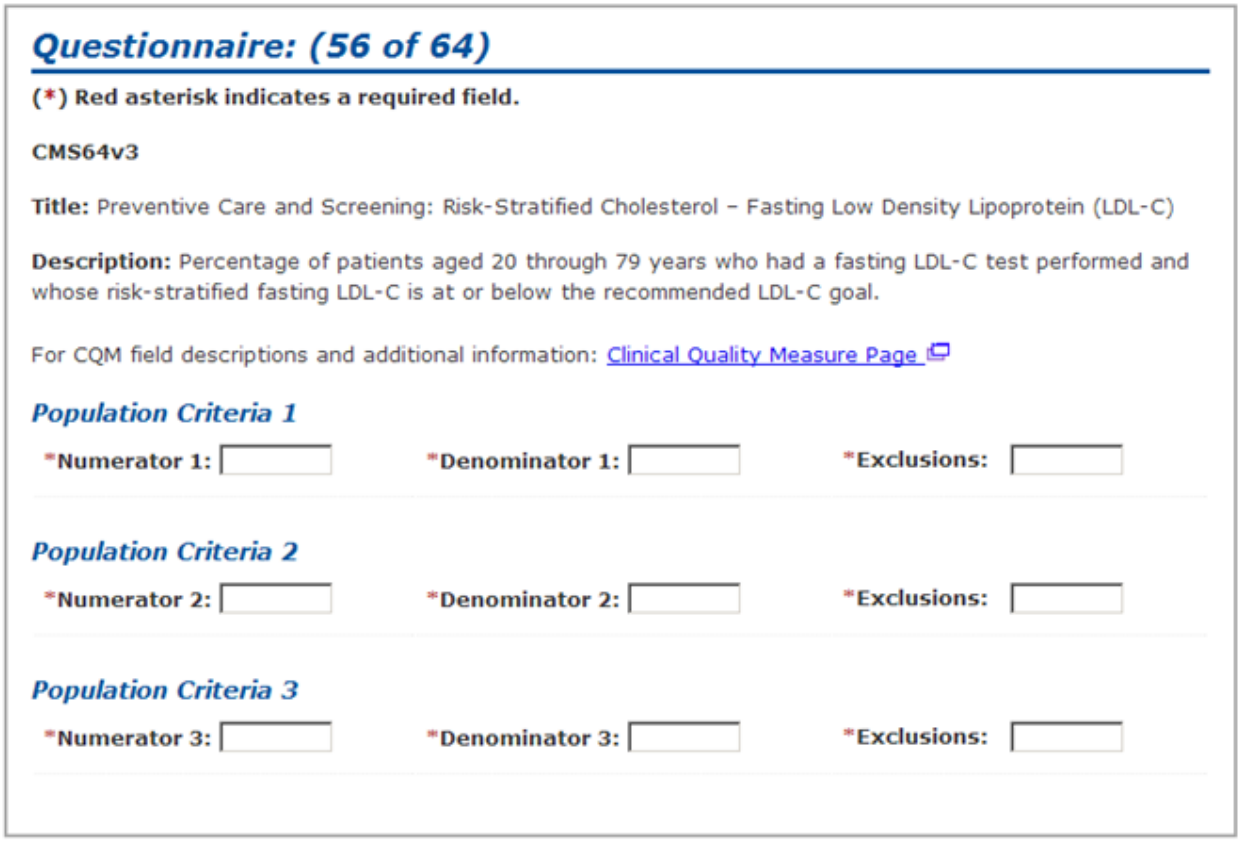


Figure 153 - CQM Question 56 Preventive Care and Screening: Risk-Stratified Cholesterol-Fasting LDL-C

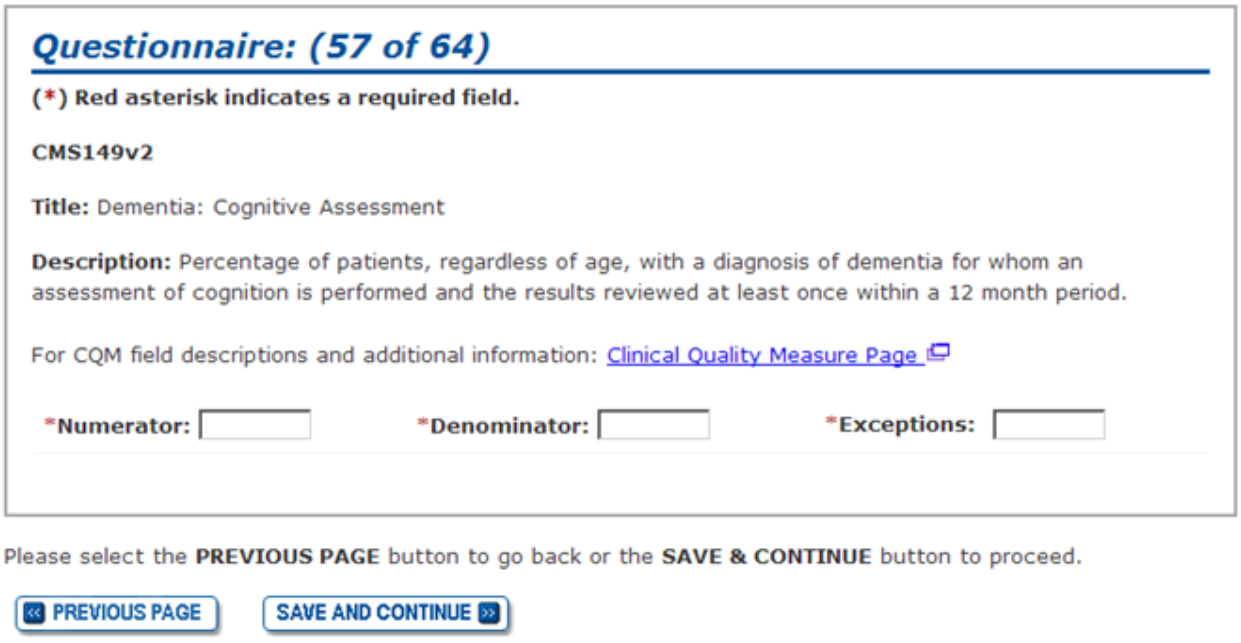


Figure 154 - CQM Question 57 Dementia: Cognitive Assessment

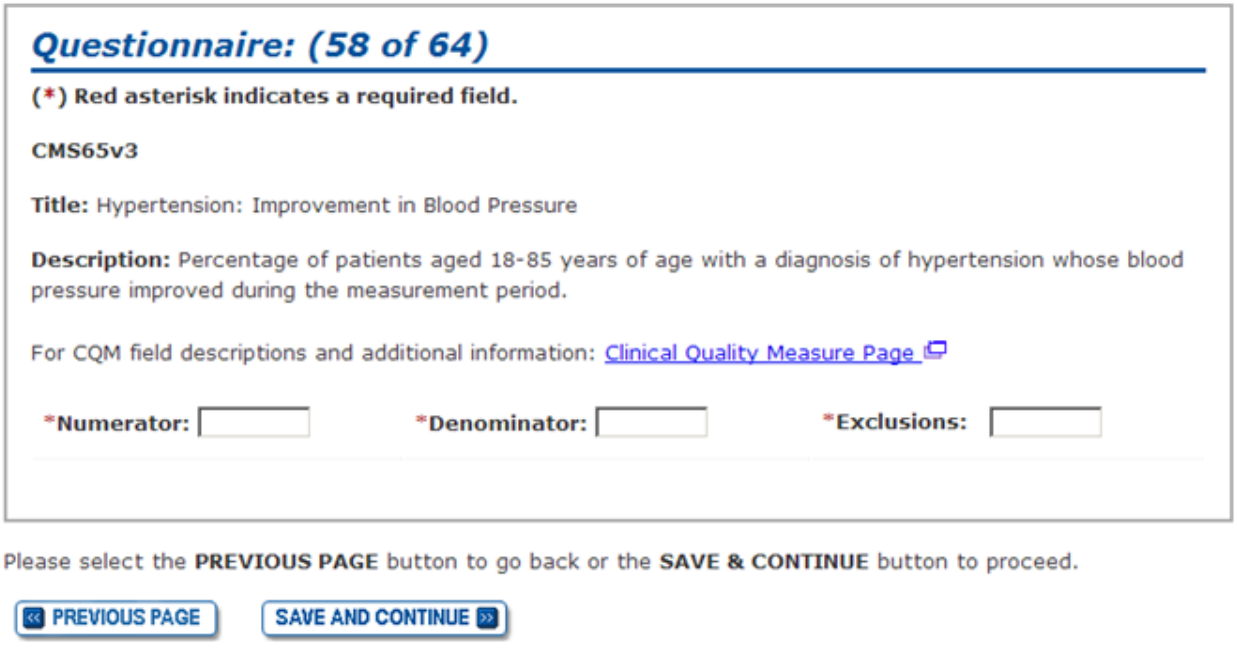


Figure 155 - CQM Question 58 Hypertension: Improvement in Blood Pressure

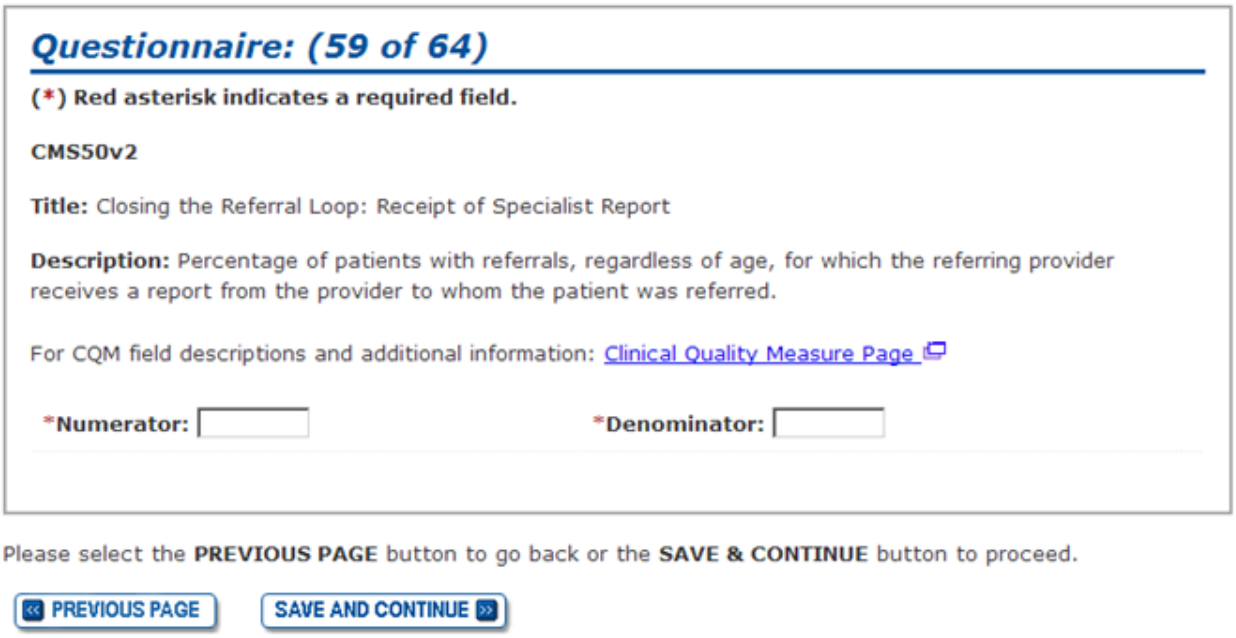


Figure 156 - CMQ Question 59 Closing the Referral Loop: Receipt of Specialist Report

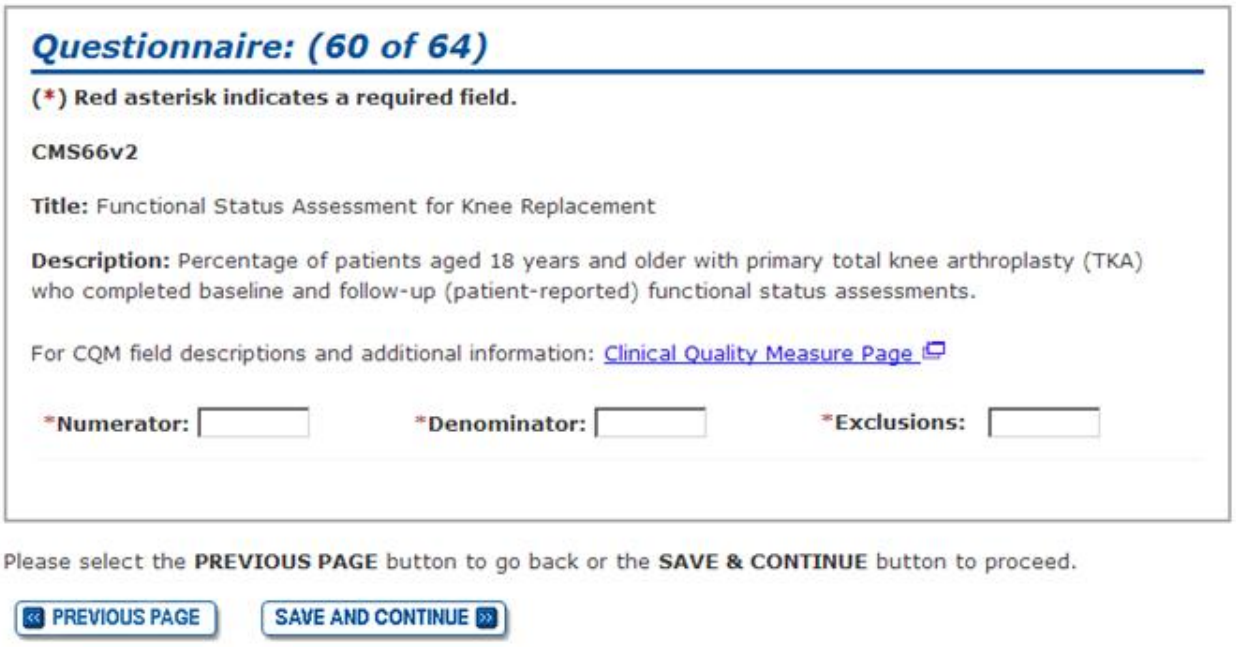


Figure 157 - CQM Question 60 Functional Status Assessment for Knee Replacement

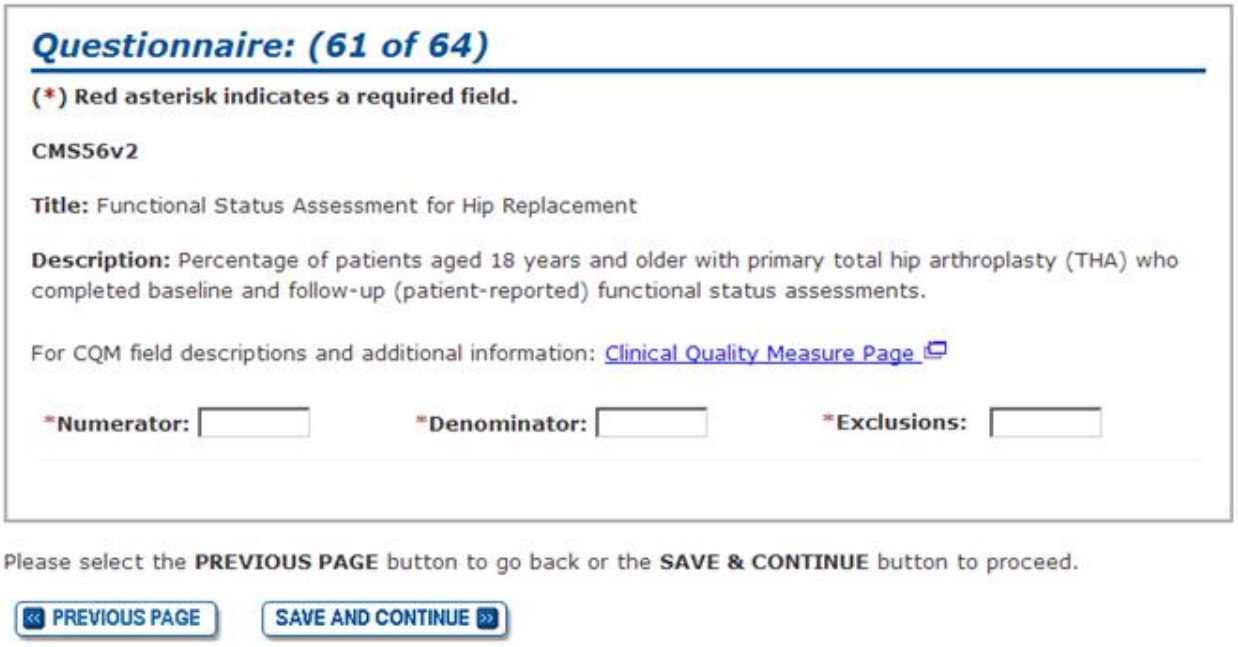


Figure 158 - CQM Question 61 Functional Assessment for Hip Replacement

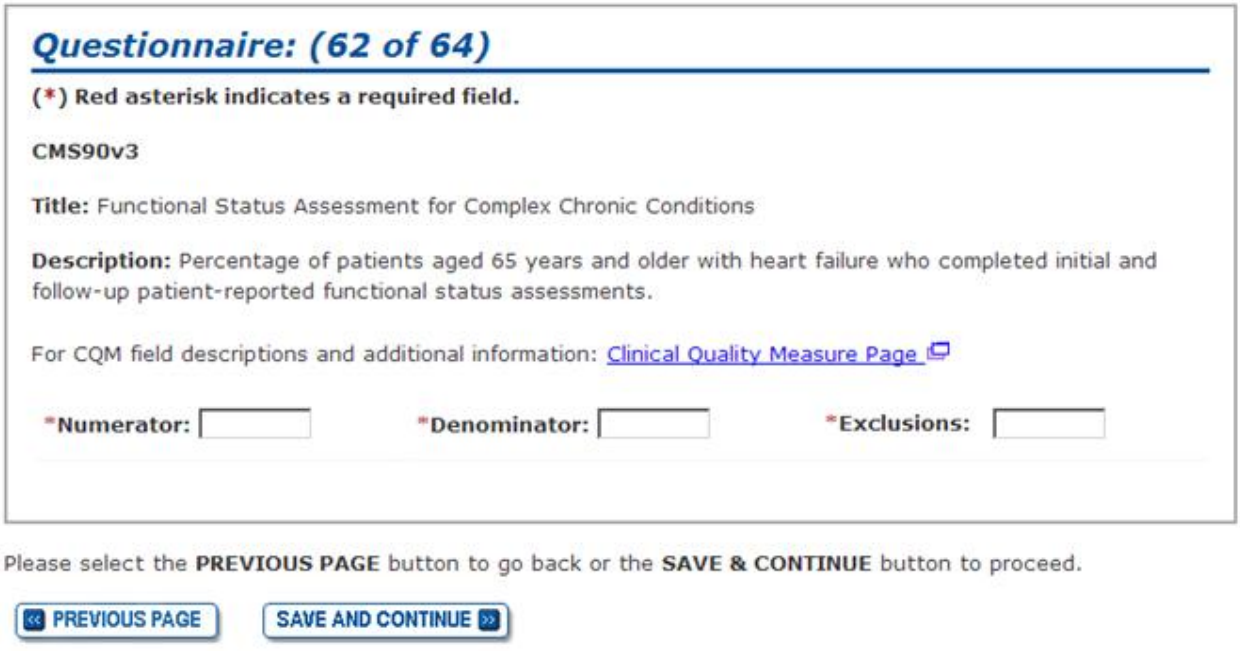


Figure 159 - CQM Question 62 Functional Status Assessment for Complex Chronic Conditions

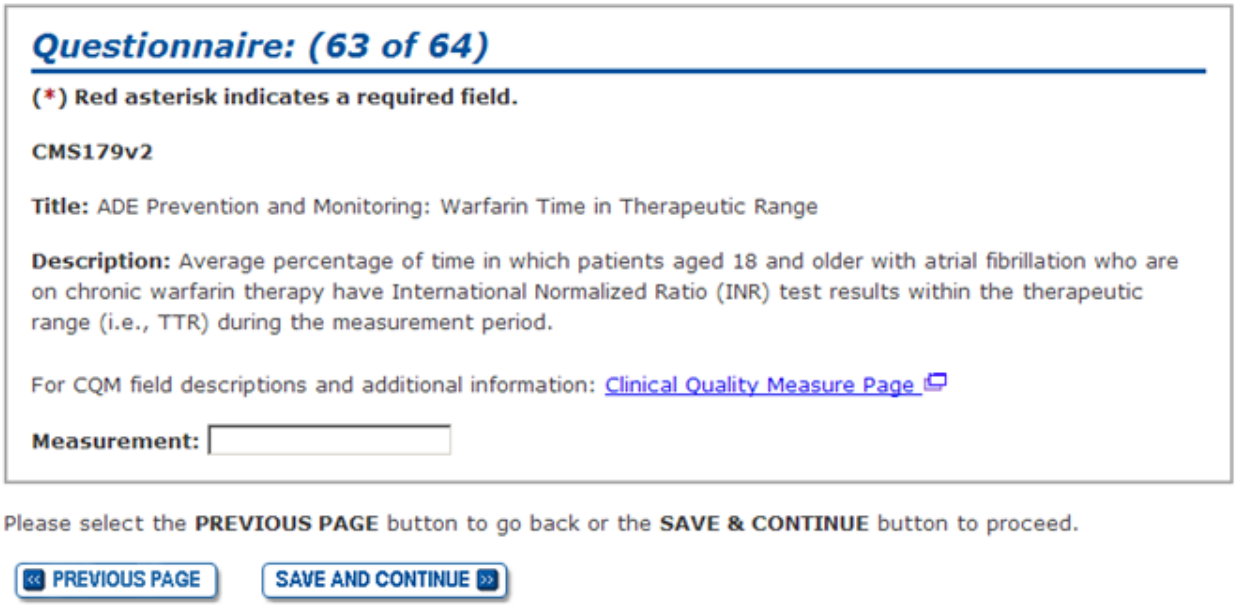


Figure 160 - CQM Question 63 ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range

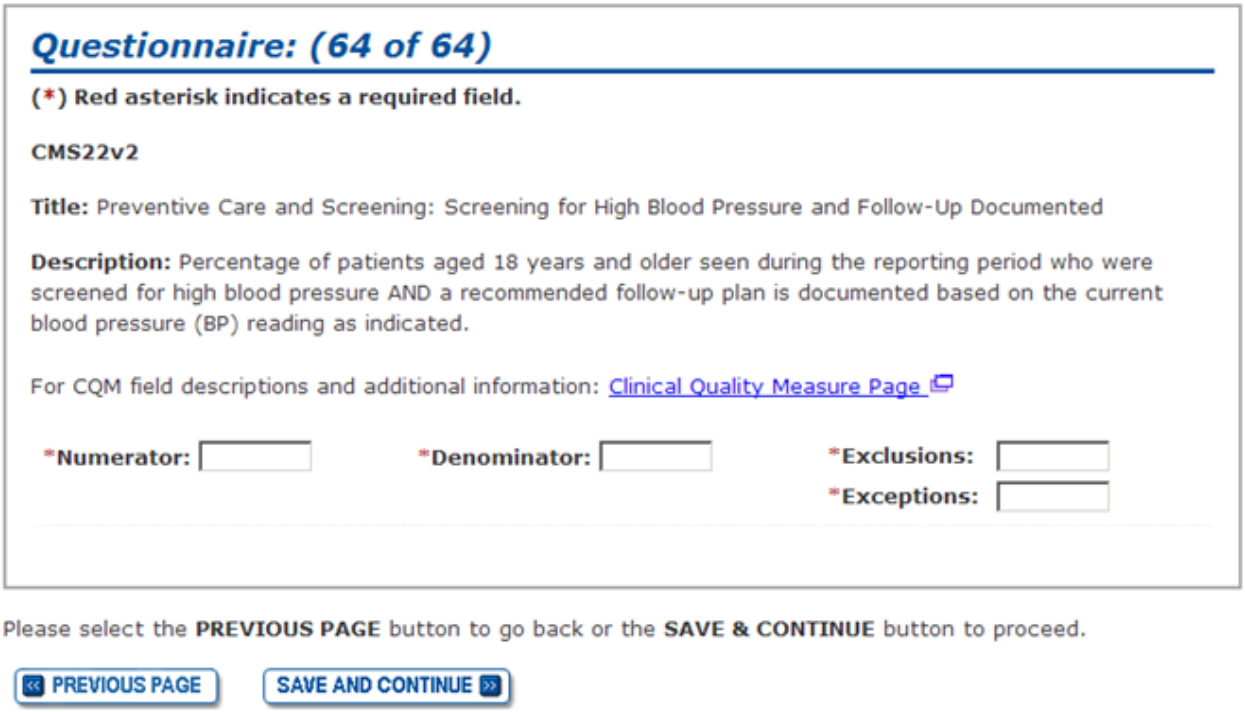


Figure 161 - CQM Question 64 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented